The Kaiser Permanente Mid-Atlantic States: Engendering Medical Group Evolution

Bernadette Loftus, MD

Associate Executive Director for the Mid-Atlantic States

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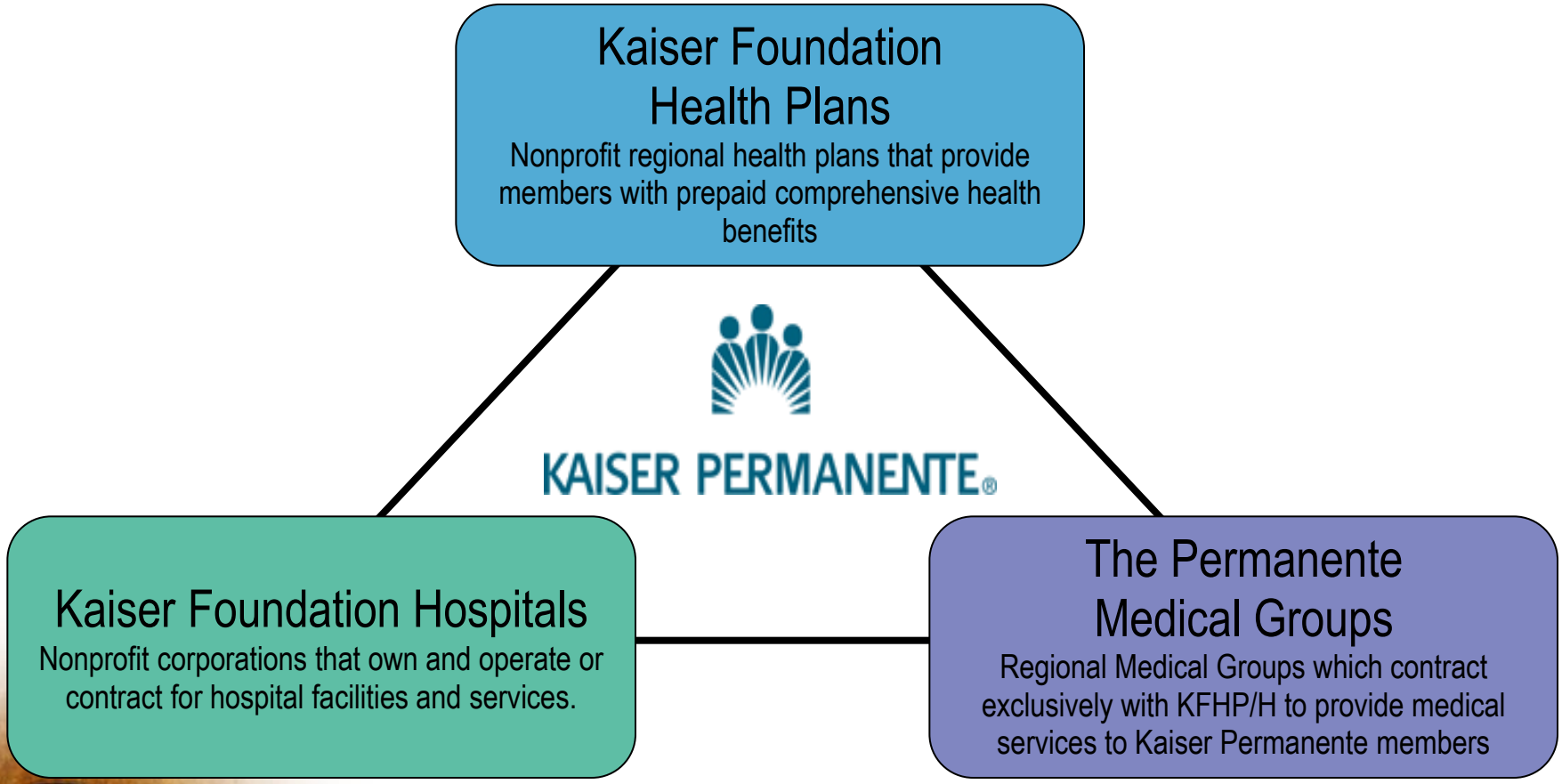
MAPMG
Mid-AtlanticPermanente Medical Group

KAISER PERMANENTE®

Who is Kaiser Permanente ?

We are a partnership of corporate entities

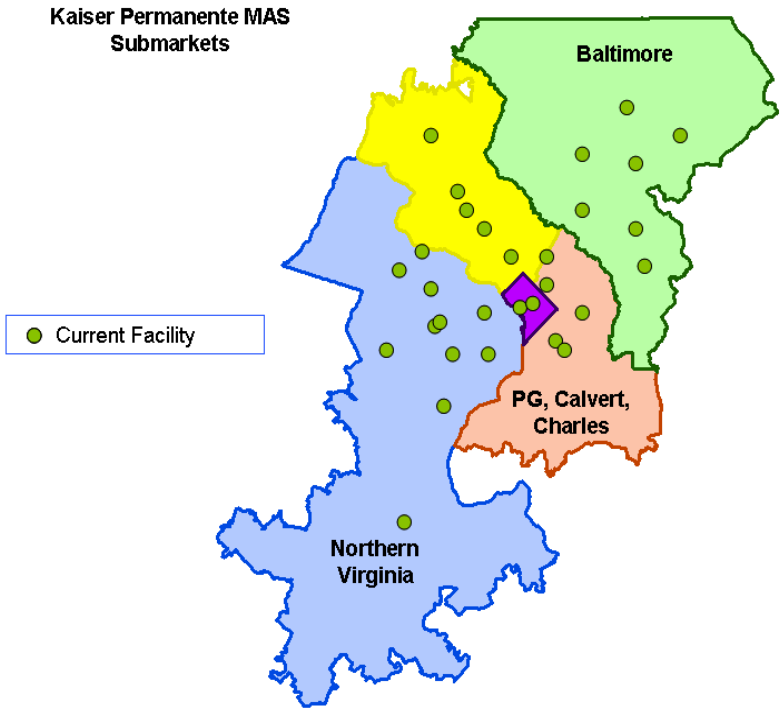


Kaiser Permanente in the Mid-Atlantic

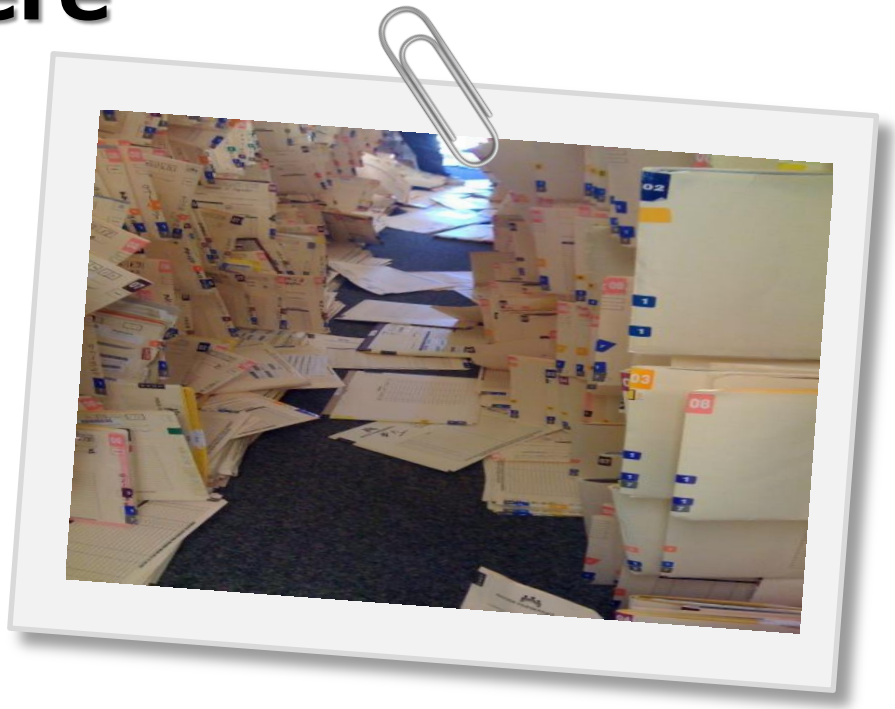
With the largest multi-specialty physician group practice in the region, supported by state-of-the-art technology, Kaiser Permanente offers our members superior quality, market-leading convenience, and highly coordinated care.

Fast facts:

- Located in the District of Columbia, Maryland and Virginia
- 503,009 members, including 124,000 Federal enrollees
- Over 1,000 Mid-Atlantic Permanente Medical Group physicians
- ~6,000 employees
- 30 medical facilities (Five Hubs)
- 24 hours / 7 days / 365 days care available
- Fully supported by Comprehensive EMR



The quest – model of choice everywhere



2008 and prior

- Long-standing, blazing success in California
  KPMAS not our strongest region.
- Mid-Atlantic Region ready to re-dedicate to the very “DNA” of KP - Fully integrated, highly-coordinated, complete care delivered to KP members.

East Coast – West Coast Affiliation

Question: What went wrong? Answer: *Completely forgot the founding "DNA"*

- **Tried to be an indemnity insurance company, not an integrated delivery system delivering accountable care**
- **Critically absent : a coherent hospital strategy**
- **Foreign DNA plasmid inserted in genome – external, fragmented care equal to (maybe better than?) internal care → inevitable rising costs**
- **Low quality modes of entry (a predilection for distressed assets), with no (or barely) critical mass**
- **And - a real failing - did not mindfully transfer intellectual capital from the "founding" regions to new regions, so that history, culture, mission, "DNA" could be transferred as well**

Turning It Around: Part 1

- **IT investment – systems for population attribution and strict panel management**
- **Electronic consult transmission and immediate scheduling**
- **Improved in-visit population care systems**
- **Systemic and systematic re-design and implementation of performance reporting**
- **Development of systems/processes: access, patient satisfaction, quality, patient safety, hospital performance, expenses – pretty much in that order**
- **Some capital investment required to achieve rough comparability with California capabilities**
- **Upgraded some buildings to enable conveniently co-located services (particularly specialty, diagnostic, procedure care, lab, pharmacy)**

Catch 'Em At Every Turn

We have a structural incentive to "catch them at every turn" but provide the systems to make it easy on the provider (and the patient)

- **Inreach** – leverage *KP HealthConnect*
- **Outreach** – leverage *CarePoint*

Members have little choice but to do the right thing when we are vigilant *(and it is easy for them)*

Performance Reporting

REGION MA
AREA NOVA
PHYSICIAN NGUYEN, LO-AN T (M.D.)
MOB RESTON
DEPARTMENT Internal Medicine

	Q4-09	Q1-10	Q2-10	CURRENT	Regional Rank	Local Rank	Target	Total pts not at target
Asthma: Use of Appropriate Medications	100%	100%	100%	100.0%	36 of 289	5 of 14	96%	-
Current # of eligible asthma patients : 8								
Dept Avg	90.1%	90.4%	91.8%	91.4%				
Cardiovascular Conditions: Lipid Control	80.6%	85.2%	93.1%	93.0%	1 of 228	1 of 10	68%	4
Current # of eligible CAD(CVD) patients : 57								
Dept Avg	59.9%	62.2%	65.7%	66.5%				
Diabetes: Lipid Control	81.7%	85.1%	87.7%	85.9%	2 of 231	2 of 11	68%	18
Current # of eligible diabetes patients : 128								
Dept Avg	58.9%	59.7%	63.1%	62.6%				

Belt and Suspenders: Forward-sweep

NOVA - Mammogram and/or Pap Smear Due Forward Sweep with Future Appointments: 03/07/2014-03/14/2014

Report Criteria: NOVA Pts with Breast Cancer Screening or Cervical Cancer Screening Coming Due or Over Due with a PCP or non-PCP appointment within a week. Excludes patients who do not want to be contacted.

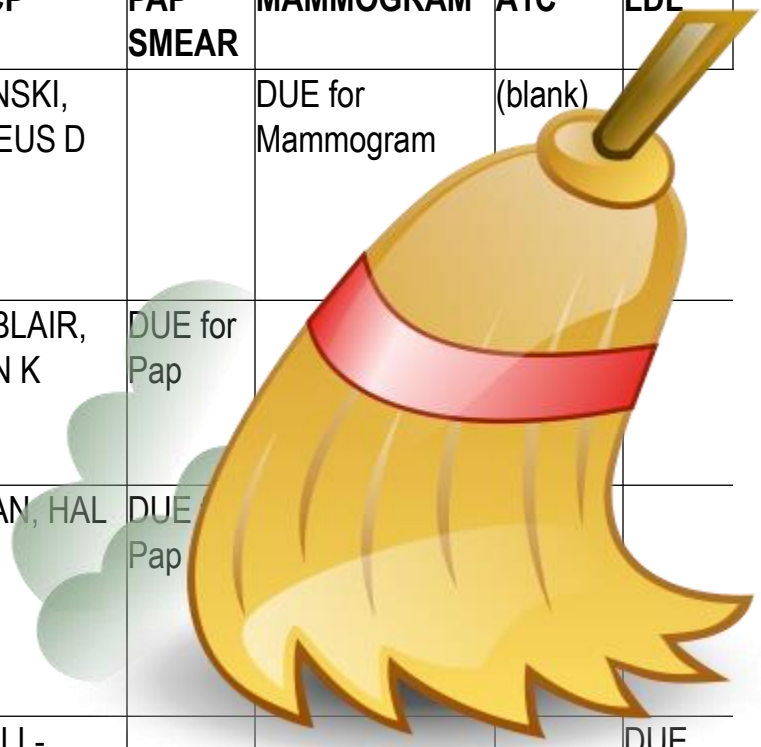
Patient Name	Next PCP A…	Non-PCP	Next Non-PCP Appt Clinic/Dept	Breast Cancer Screening Coming Due	Cervical Cancer Screening Coming Due	Kp.org Active	A1c Due in DM	LDL Due in CVD
SMITH, JANE			**N/A**	YES	**YES**	YES	**NO**	NO
MOUSE, MIN		A	**N/A**	YES	**YES**	NO	**NO**	NO
ROSE, JA		/A	**N/A**	YES	**NO**	NO	**NO**	NO
THOMA			**N/A**	YES	**NO**	NO	**NO**	NO
SMITH, JA	**N/A**	3/11/2014 10:10:00 AM	**NOVA-MA S-MA/NEUROLOGY SPRGFLD**	YES	**YES**	NO	**NO**	NO
MOUSE, MINNIE	**N/A**	3/7/2014 3:45:00 PM	**NOVA-MA P-MA/ALLERGY SHOT WOODBRG**	NO	**YES**	YES	**NO**	NO

Belt and Suspenders: Back-sweep

This report shows all visits that took place for patients that were due for a Health Maintenance procedure of a Pap Smear, Mammogram, A1C, and/or LDL and was not performed or ordered.

Backsweep Report for Visits Between 12/1/2013 and 12/31/2013

DEPARTMENT_NAME	PATIENT NAME	PROVIDER LAST SEEN	APPT DATE	MEDICINE PCP	GYN PCP	PAP SMEAR	MAMMOGRAM	A1C	LDL
ALLERGY LARGO	SMITH, JANE	GREENE, GEOFFREY (M.D.)	12/20/2013	AGUINALDO, CIELITO M (M.D.)	MAMIENSKI, THADDEUS D (D.O.)		DUE for Mammogram	(blank)	
ALLERGY SO BALT	MOUSE, MINNIE	PATEL, PARAG N (M.D.)	12/26/2013	TU, CHRISTINE (M.D.)	RABIN BLAIR, LAUREN K (M.D.)	DUE for Pap			
ALLERGY SPRGFLD	ROSE, JANE	VROOM, JOHN (M.D.)	12/20/2013	DAVISON, REBECCA J (M.D.)	HINDMAN, HAL (M.D.)	DUE Pap			
	THOMAS, CINDY	SCRANTON, STEPHEN E (M.D.)	12/27/2013	MAGBUHOS, CELERINO M (M.D.)	WADDELL-JIGGETTS, BEVERLY J (M.D.)				DUE for LDL



Belt/Suspenders/Raincoat/Umbrella/Galoshes

"If we didn't reach you before you came in, and we didn't reach you while you were in, we'll reach you after you leave"

RE-SWEEP REPORT - PATIENTS WHO HAD A CARE GAP FROM NOVEMBER 2013 REPORT (VISITS THROUGH JANUARY 29, 2014)

Backsweep roll-up Report

Mems with "Due For" Flag on 10/31/201

Visits in November 2013

sa	Spec	# of mems seen who needed a Pap Smear	% pap satisfied	# of mems seen who needed a Mammogram	% mam satisfied	# of mems seen who needed an a1c	% a1c satisfied	# of mems seen who needed an LDL test	% LDL satisfied
BALTIMOR									
	Al y	0		2	50.0%	0		0	
	C	0		1	100.0%	0		2	50.0%
	C Abuse	1	0.0%	0		0		0	
	D	1	100.0%	2	0.0%	1	0.0%	0	
	End ism	2	50.0%	1	0.0%	0		0	
	Family Practice	12	41.7%	14	14.3%	1	100.0%	1	0.0%
	Gastroenterology	0		7	14.3%	1	0.0%	2	0.0%
	Hematology/Oncology	1	100.0%	0		0		2	0.0%
	Internal Medicine	28	32.1%	30	20.0%	6	0.0%	7	14.3%
	Neurology	1	0.0%	2	50.0%	1	0.0%	0	

Turning It Around: Part 2

- **Culture and know-how transfer critically needed**
- **Seasoned physician leaders "imported" from California – they knew what it was supposed to look like in full flower, so it was easier to move fast with them**
- **Lots of emphasis on "Turning Doctors Into Leaders"** – significant, and mindful, investment in physician leadership development**
- **Physician leadership and integral involvement in Regional strategy was *sine qua non ;* a "health plan"- focused region could not design or improve care**
- **Clear messaging (and sell job!) that internal care, documented in EMR, is almost always better than external, fragmented care**

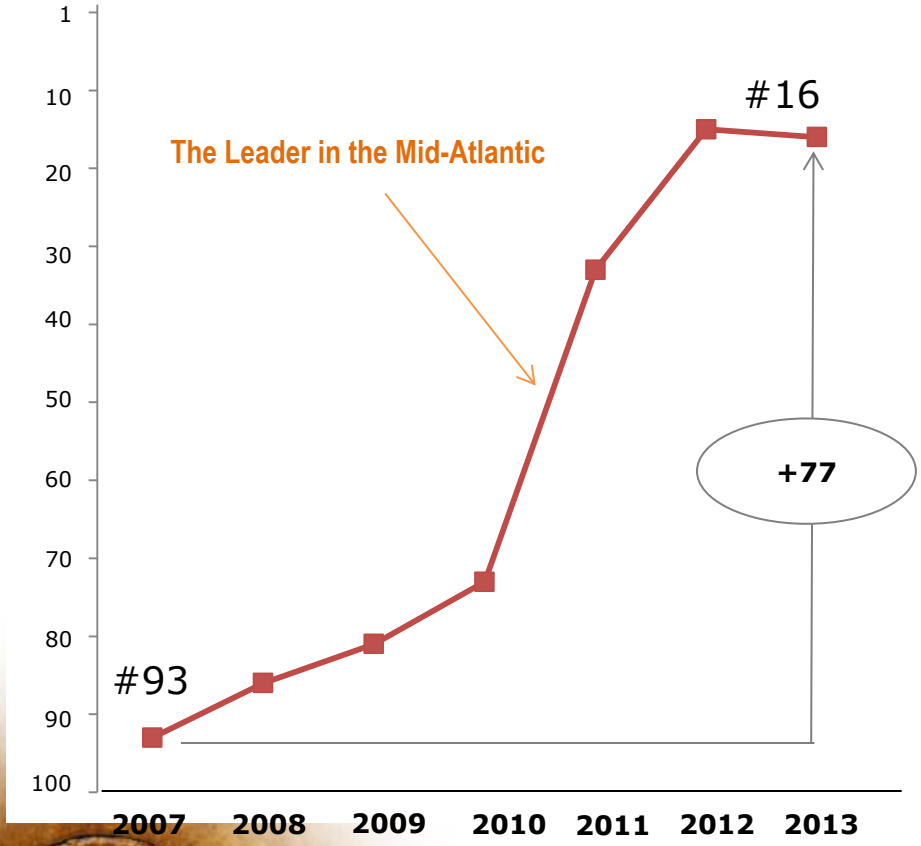
– ** an homage to Dr. Thomas Lee, "Turning Doctors Into Leaders", HBR, March 2010

Turning It Around: Part 3

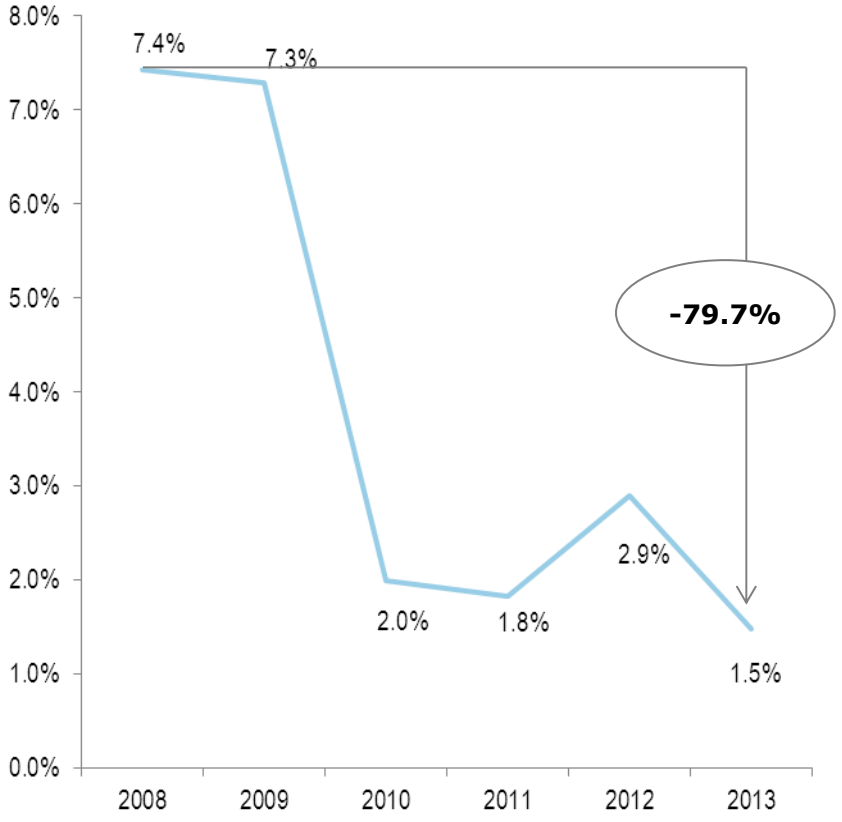
- **A re-dedication to "owning" the hospital and post-hospital portion of the continuum**
- **Systematically redefining relationships with fewer hospitals that are like-minded, and staffing them with our physicians**
- **General observations on turnaround:**
  - ✓ **Focus, focus, focus – on execution.**
  - ✓ **It's not enough to think big thoughts – implementation must be a core competency. Corollary observation - lots of people like to dream up solutions, but fewer are willing to do the hard work of rolling up sleeves and getting it done.**
  - ✓ **Think BIG, Start small, Move *fast;* must create a sense of urgency**

Increasing our value proposition

Kaiser Permanente Mid Atlantic
US National Health Plan Ranking 2009 - 2012



Medical Services Trends
2008-2013



Medical Services Trends includes inside and external expenses including: Med Group, Optical, and MOO (excluding drugs and meds, facilities, and transfer items), Professional Referrals, Facility expenses(PTNP), Other Benefits, and Hospitalization

* NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations. It also recognizes clinicians and practices in key areas of performance. NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used performance measurement tool in health care. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
** NCQA's Private Health Insurance Plan Rankings 2009–2013

Demonstration of the superior value we deliver

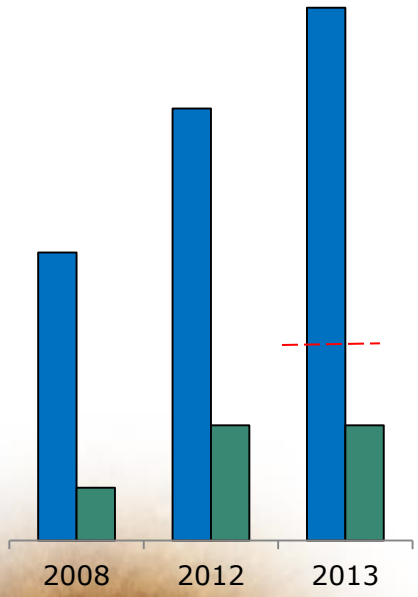
Patient Experience: Service as measured by key CAHPS metrics

Kaiser Foundation Health Plan of the Mid-Atlantic States

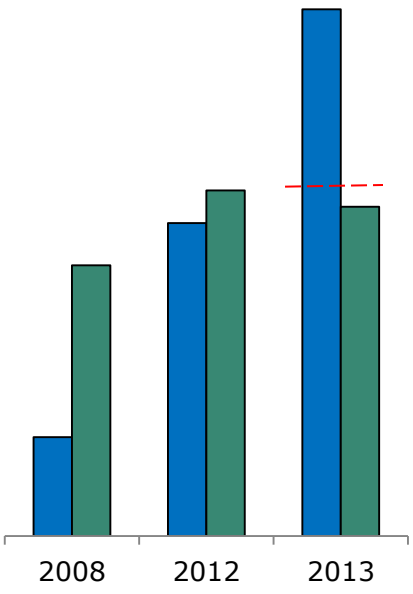
All Plan/All Line of Business Mean Score

------ 2013 Rating of 2nd highest commercially available local competitor

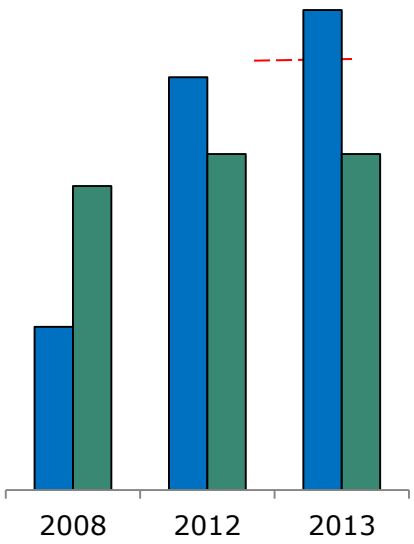
Rating of Health Plan*



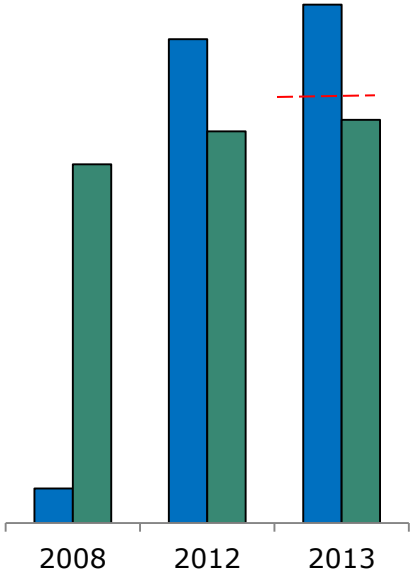
Rating of All Health Care*



Rating of Personal Doctor*



Rating of Specialist Seen Most Often*



Kaiser's 2013 Rates *exceed* the 90th percentile and all commercially available local competitors

* Scores are the percent of respondents rating the item a 9 or a 10 on a 10 point scale

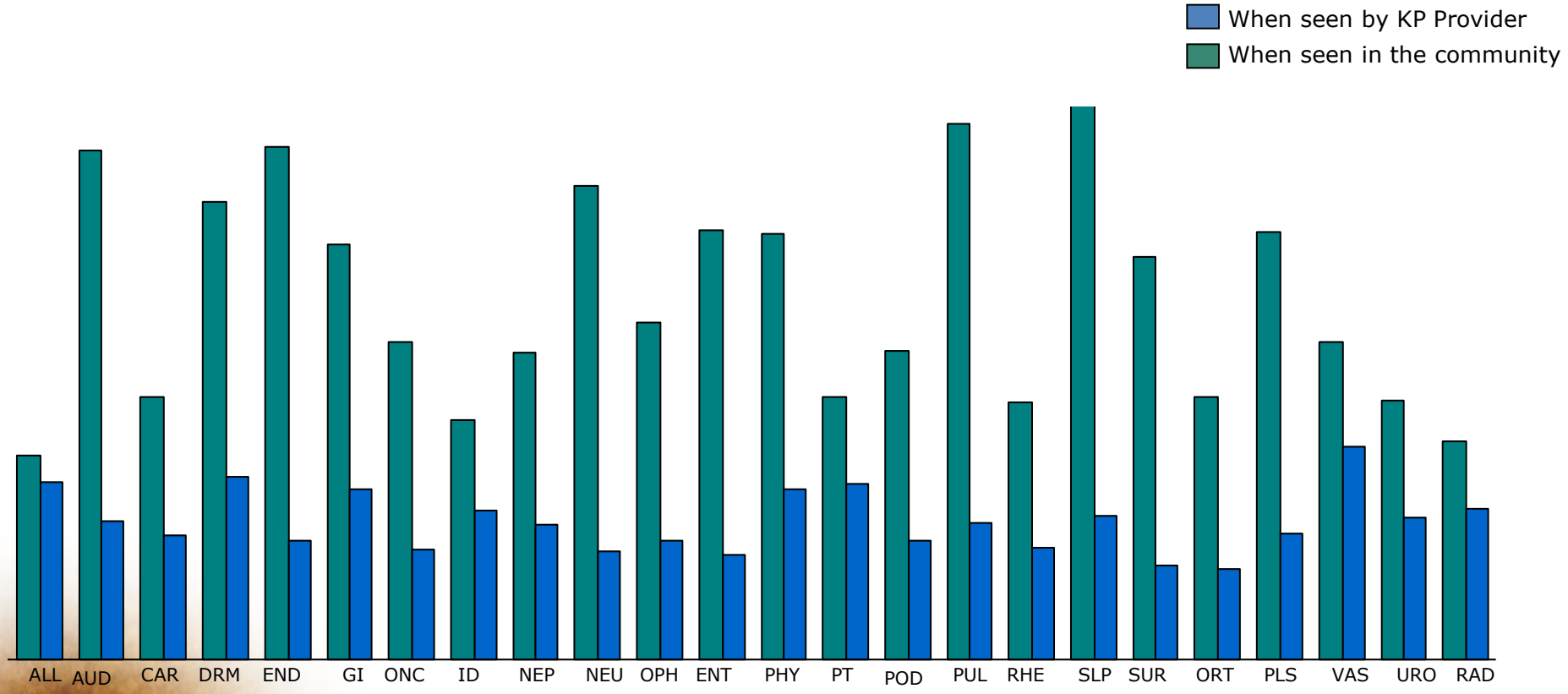
NOTE: The source for data contained in this publication is Quality Compass® 2012-2013Commercial data and is used with the permission of the Committee for Quality Assurance (NCQA). Quality Compass 2012-2013includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Operational improvements go beyond quality

Access to specialty care is rapid

Wait Time from referral initiation to appointment completion for KP Members*

Number of days from initiation of referral to completion of specialist office visit



Between one-quarter and one-third of patients are seen by specialists the same or next day from their primary care encounter

* Data is from Nov 2013 (lagged 3 months from current so that claims data can be processed to ensure we know when external providers saw the patient); results are reflective of what is seen every other month

Redefining Great Access to Care

If you need to be seen face-to-face, we want to see you ASAP!
Goal: 40% of patients seen same day as referral, or the next day

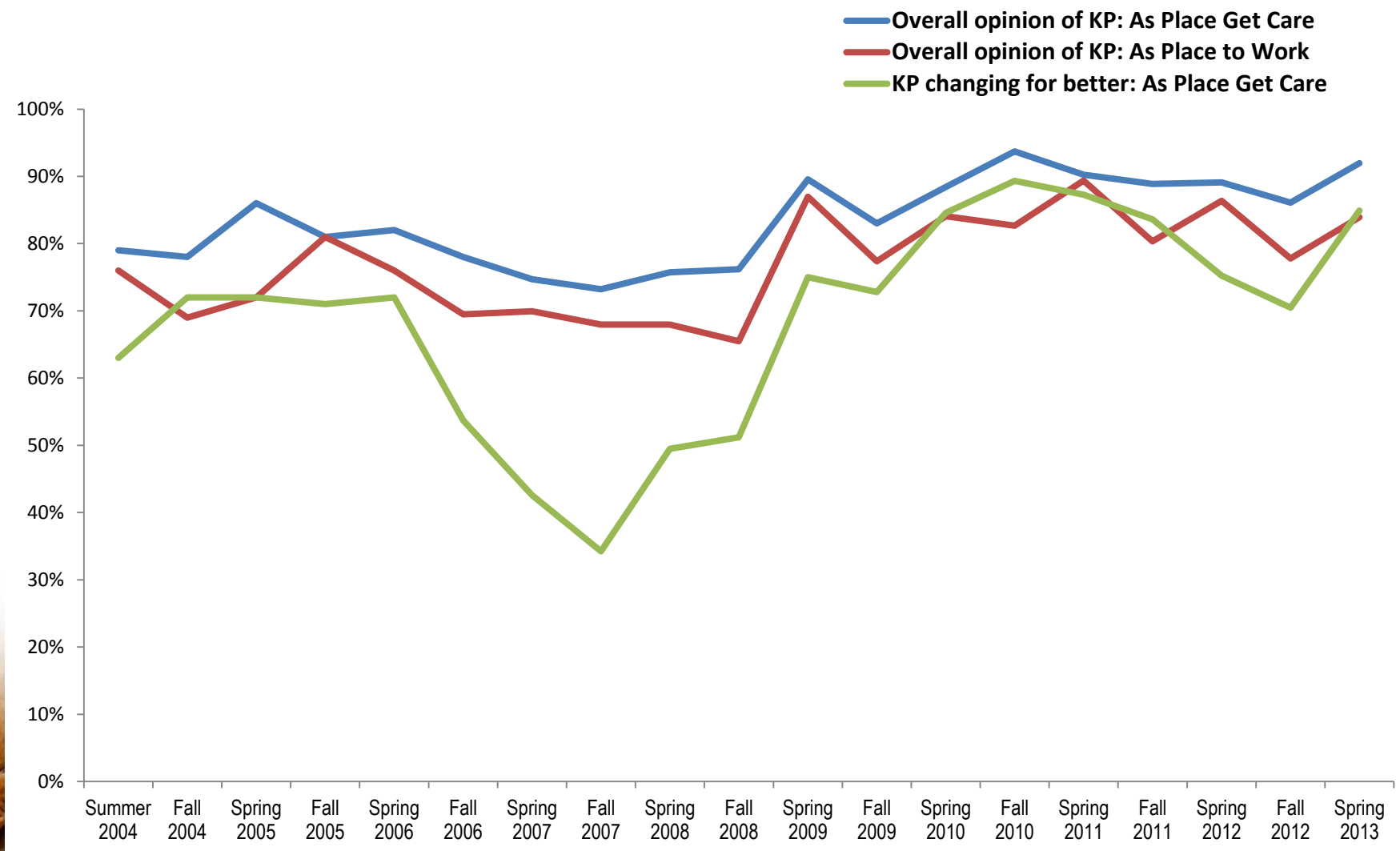
Same Day + Next Day Specialty Care Access - Rolling 12 months - Regional

Regional | BALT | DCSM | NOVA | Print Current View

Same Day + Next Day Specialty Care Access for Regional- Mar-13 thru Feb-14

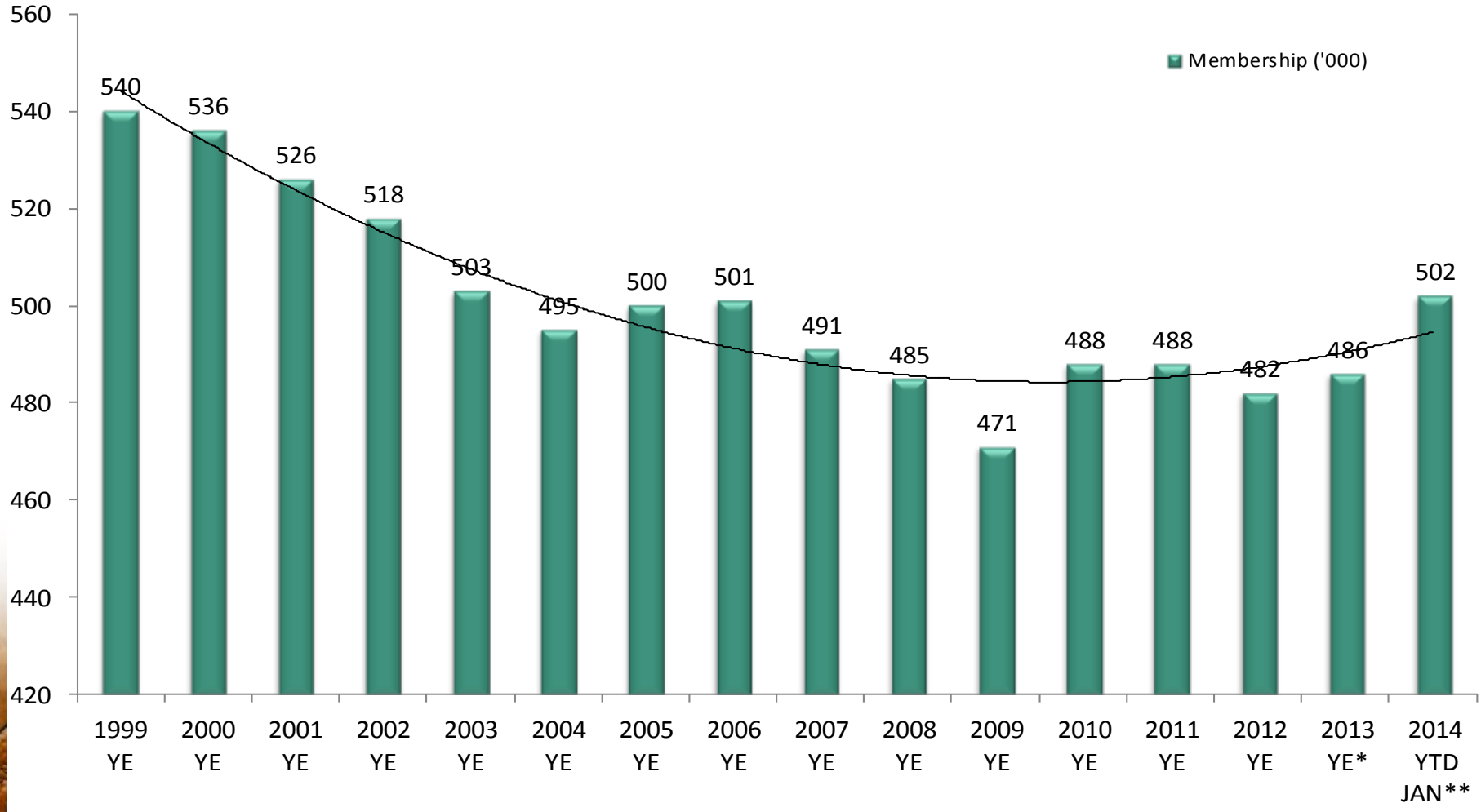
Specialty	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
ALL	24%	17%	21%	20%	28%	29%	29%	33%	31%	31%	37%	34%
ALT	17%	17%	21%	21%	29%	29%	28%	35%	23%	32%	37%	35%
CAR	29%	28%	32%	34%	35%	31%	36%	40%	46%	55%	49%	48%
DRM	21%	24%	28%	16%	9%	9%	10%	19%	20%	33%	43%	37%
END	17%	16%	25%	23%	29%	25%	27%	38%	39%	41%	36%	32%
ENT	23%	27%	39%	35%	45%	35%	33%	43%	42%	52%	53%	51%
GI	15%	15%	19%	21%	20%	26%	20%	22%	29%	38%	24%	26%
ID	22%	29%	35%	30%	38%	38%	48%	40%	43%	43%	43%	46%
NEP	18%	20%	22%	22%	35%	17%	26%	26%	23%	33%	38%	44%
NEU	25%	24%	29%	28%	33%	29%	34%	40%	47%	49%	46%	39%
ONC	16%	19%	24%	23%	32%	24%	31%	40%	37%	37%	29%	35%
OPH	42%	40%	46%	43%	48%	53%	52%	56%	52%	60%	58%	60%
ORT	28%	26%	31%	29%	46%	47%	48%	48%	53%	54%	52%	47%
PAI	22%	20%	32%	35%	44%	29%	31%	38%	33%	32%	41%	40%
PHY	17%	24%	31%	15%	25%	29%	19%	29%	16%	20%	14%	25%
PLS	23%	20%	19%	15%	25%	25%	44%	31%	30%	25%	26%	32%
POD	32%	28%	42%	42%	33%	34%	37%	38%	43%	54%	50%	47%
PUL	25%	25%	40%	35%	43%	44%	52%	51%	45%	53%	45%	49%
RHE	26%	27%	32%	28%	41%	40%	36%	35%	37%	43%	40%	42%
SPS	28%	19%	29%	16%	36%	20%	37%	27%	17%	40%	28%	24%
SUR	26%	27%	38%	34%	37%	37%	36%	42%	49%	49%	48%	45%
URO	18%	20%	35%	24%	32%	27%	28%	26%	31%	39%	36%	37%
VAS	13%	18%	17%	21%	26%	22%	22%	29%	33%	31%	37%	33%
SLP-MD	9%	15%	20%	32%	26%	41%	33%	12%	19%	24%	29%	42%
Weighted Avg:	25%	25%	33%	29%	34%	33%	34%	37%	40%	46%	46%	44%

Physician Morale



Source: Brand Strength Monitor (BSM) Report. The Brand Strength Monitor (BSM) was implemented in 2004 to achieve two main objectives: monitor changes in the strength of the KP brand over time on critical dimensions across stakeholder groups; and monitor the trends in KP's closing of the image gaps and opening image advantages relative to our competitors on key dimensions of our brand. These reports cover trends from the baseline to the present. BSM is conducted in two waves (Feb. to June and July to Nov.) each year with the following seven stakeholder groups: members and non-members, employees, physicians, employers who offer KP and employers that do not offer KP as well as brokers.

Membership Through the Decades…An inflection point?



*486,037, Year-end 2013 membership growth
** 16,318 membership growth

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

— Margaret Meade

Key Take-Aways

What we found critical

- Clear vision & “imperatives” – be audacious in goal-setting.
- Engagement of the entire care team led by physicians. Collaboration is critical.
- Culture of excellence is expected… not optional.
- Robust reporting system.
- Culture of accountability & being valued.
- The hospital partner is critically important: Must have aligned vision/values
- Patient acceptance of the model is dependent on them really feeling the value (Quality + Patient Experience/Cost)

What is not essential

- Perfect data that everyone agrees is incontrovertible.
- A detailed roadmap with every step plotted out.
- Complete consensus of everyone on the team.
- Absolute consistency driven by an assumption that what works one place will certainly work elsewhere.

Questions?

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