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Kaiser Permanente – California: A Model for Integrated Care for the Ill and Injured

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Executive Summary

Kaiser Permanente (KP) is the nation's largest nonprofit integrated health care system with over 9.6 million members. KP-California consists of the Northern and Southern California Regions. KP is a pre-paid integrated system consisting of three distinctly separate, but related entities: a health plan that bears insurance risk, medical groups of physicians, and a hospital system. The financial incentive is to provide high quality, affordable care and manage population health rather than generating high volume of compensable services. Both the health plan and the medical group are aligned and accountable for a global budget, and only contract directly with one another for the provision of medical services. All three entities share in the goal, reflected in the organization's capitated payment system, of keeping patients healthy while optimizing utilization. This alignment is crucial in KP's effort to maintain affordability for their purchasers and members.

KP-California is often seen as a prime example of integrated care. The aligned structure and underlying contractual relationship between entities is the backbone that has led to the design of an efficient acute care delivery system that addresses a patients needs across the continuum of care and maximizes population health. To aid in managing demand for care and directly connecting with members, there is around the clock telephone access to nurses for clinical advice. To facilitate care, physicians have access to a plan-wide electronic health record (EHR) system that contains every member's complete ambulatory and hospital medical history. Additionally, KP has developed a number of acute and emergency clinical pathways and protocols that do not discourage physicians from spending more time with each patient as needed, that encourage ED use of diagnostics and consultations in the pursuit of clinically appropriate dispositions, and provide the tools and infrastructure to shift non-emergent care to more appropriate and cost-effective settings. Finally, KP has developed ambulatory "transitional care" programs for some common high intensity chronic medical conditions that help manage patients before they need to seek ED care and upon hospital discharge.

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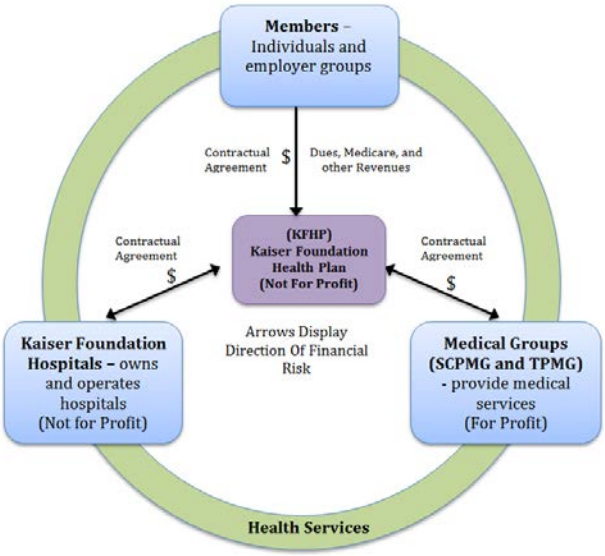
I. Program Overview

KP has its roots in the delivery of emergency care. In 1941 shipbuilder Henry Kaiser invited physician Sidney Garfield, who had already founded two pre-pay (daily prospective payments from insurers) hospitals, to provide health care to Kaiser's shipyard workers. The first KP hospital opened at the Richmond Shipyard in 1942 to provide emergency care to acutely ill and injured workers.[1] The hospital acted as a mid-level component in a medical/triage system that also included six aid stations and a larger hospital in Oakland for the most critical patients. When World War II ended, Kaiser and Garfield opened the "Permanente Health Plan" system to the public and over the next 75 years Kaiser would grow from 90,000 members to 9.6 million members.

KP's business model and structure has largely remained unchanged since it was founded, which is at the core of its long term success. In KP-California, there are three components (See Figure 1):

- **Kaiser Foundation Health Plan (KFHP)**: a non-profit health plan (insurance company), which has a mutually exclusive contract with the Permanente Medical Group physicians to provide care to their membership.
- **Kaiser Foundation Hospitals (KFH)**: Non-profit hospital system.
- **Permanente Medical Groups (PMGs)**: Southern California Permanente Medical Group (SCPMG) and The Permanente Medical Group, Inc. (TPMG) are for-profit self-governed entities that have mutually exclusive contracts with KFHP for provision of health services to its members. PMGs provide clinical services in the KFH's, and are accountable for the 24/7 provision of care for all clinical specialties. The medical groups are responsible for all clinical care decisions, so no prior authorization or gate keeping requirements are imposed by KFHP or KFH.

Figure 1: Contractual agreements between Plan members, Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and Permanente Medical Groups[2]



Although each is a separate entity, the KFHP and KFH share board members and senior leadership. This helps facilitate decision-making and prioritization/allocation of capital between the health plan and the hospital facilities. Each entity in the system contracts exclusively with the other Kaiser entities (i.e. KFHP contracts only with PMGs and PMG physicians are prohibited from seeking contracts with other payers.)

II. Care Delivery Redesign

There are 3 main ways to reduce acute care costs: 1) preventing acute health problems and the associated care from happening in the first place; 2) create and expand less costly (and hopefully more convenient) alternatives to ED care so people with acute problems use less expensive hospital-based care; and 3) improve the function of the acute care system itself. In conceptualizing the KP approach to acute care services, it is important to understand several elements including care delivery redesign that incorporates all three of the strategies mentioned above, as well as the underlying incentives and information systems that support these services.

Acute Care Demand Management (KP OnCall). KP OnCall is the clinical advice center for KFHP members in Southern California. All KFHP members have around the clock telephone access to nurses who can direct patients to the most appropriate setting—whether the clinical condition warrants an immediate appointment in an ED, a direct referral to a specialist, or can be handled through a next day follow-up with primary or specialist care. The aim of the program is to guide members to the most appropriate clinical venue based on the nature of their symptoms or concerns, which indirectly reduces ED demand. KP OnCall is managed by SCPMG, but owned by KFH. Out of the 850,000 calls received in 2011, 34% were safely managed with primary care appointments and/or care in non-ED ambulatory settings, 15% were directed to urgent care clinics, 10% were provided advice for home care, 1% were advised to call "911," and only 18% were sent to EDs. The remainder had non-advice related calls.[2] Kaiser has studied the effectiveness of OnCall further and found that of the members who called and indicated they would have gone to the ED otherwise, only 40% felt they needed to go to the ED after the call.

Standardizing Care Through Clinical Pathways. To promote more accurate and high-value ED evaluations, emergency physicians and specialists have developed a number of clinical pathways and protocols. These serve the purpose of ensuring potentially unnecessary tests and services are avoided, encourage evidence based practices, and can rapidly discharge lower-acuity patients with appropriate follow-up. Patients with undifferentiated and potentially serious conditions may spend additional time in the ED to receive advanced diagnostic services and consultations before the decision to admit, discharge, or transfer has been reached.

Ensuring Seamless Transitions of Care. With the use of the EHR (HealthConnect - described below), ED physicians are able to flag high-risk patients with chronic diseases who are frequent utilizers of the ED. Working with case managers (i.e. nurses and other clinicians who have received special training) ED physicians can transition or refer these patients to more intensive outpatient programs. These programs combine care management and more robust follow-up with the patient's primary care and other providers to ensure the transition from the ED or hospital is smoother. An example is the SCPMG Heart Failure Transitional Care Program that decreased 90-day readmissions by 30% and significantly lowered mortality and ED visits when measured from 2006 to 2010.[2]

III. Physician Payment and Information System Reforms

Payments. ED physicians receive a market-competitive base salary and are not incented by volume or procedures (i.e., they are not paid on the basis of relative value units [RVUs] billed).[3] There are, however, incentives based on quality and patient satisfaction measures. Physicians can earn an additional 6-9% based on peer and chief evaluations, quality of service and defined qualify of care metrics, patient satisfaction surveys, group contribution, and financial performance of the PMG.[4] At the medical group level and at the individual physician level, there are no financial incentives for providing unneeded services, and there is no financial gain for withholding clinically necessary care. The PMG and the emergency physicians are encouraged to provide the clinical services needed to determine the patient's appropriate clinical disposition from the ED. This includes the use of observational care, advanced testing, specialty consultation, and the arrangement of intensive follow-up care. An expedited hospital admission process remains a priority for those whom have a clear clinical need for admission.

Information System. Access to the patient's entire ambulatory and hospital information is available to emergency physicians and consultants through HealthConnect, the KP EHR. The EHR is accessible by every medical facility and provider, including the 37 KFH hospitals and some contracted non-KFH hospitals. This full interoperability allows for complete integration with longitudinal care. With HealthConnect, ED physicians can avoid duplicate care and have a comprehensive understanding of prior visits, testing, medications, procedures, and diagnoses. This helps provide more rapid throughput, and more accurate and safer care in the ED. Non-KP emergency physicians treating KP members in non-KFH ED's, can access the same information telephonically by calling the Emergency Prospective Review Program which is staffed 24/7/365 by PMG emergency physicians and nurses.

IV. Payment Model and Results

Financial alignment between entities is a critical element of KP's model of integration. The PMG's negotiate an annual budget with KFHP for the care they are to provide. There is a contractual "risk sharing arrangement" between KFHP/KFH and PMG's so that each entity shares in the favorable or unfavorable variance to budget that the other entity may experience (with limitations for specific uncontrollable exclusions). As such, both are held mutually accountable for the other entity's expenses. There are limits on PMG gains from this arrangement; there is no immediate financial gain to the medical group for withholding needed pre-paid services, and future medical expenses resulting from such a tactic would remain with the PMG. There is no financial gain for driving up high volume and high intensity services in the ED or hospital, nor would there be gain to KFH by having "insured" patients admitted to its facilities. The PMG's share in the hospital budget variance through KFHP, so it is in their best interest to see that care is delivered in the most appropriate clinical setting. Cross subsidization between entities abounds. The PMG invest heavily in services that benefit the hospitals, the hospitals provide services to enhance the ED evaluation and treatment of patients that might otherwise have been admitted, and the health plan provides the massive capital needed to support the facilities and multiple systems including the clinical system HealthConnect.

KFHP sets care expectations for the PMG's. However, the health plan does not determine the numbers or types of providers used to meet these agreed upon levels of service and quality, nor physician compensation. The PMG is responsible for meeting the agreed upon care expectations within its negotiated budget. Thus, unlike some other systems, the PMG, not the health plan, is responsible for clinical care decisions.

V. Challenges, Policy Solutions, and Next Steps

The lynchpin to KP's success is the alignment of payments through mutually exclusive contracts between the physicians and the health plan. Moving toward a Kaiser-like integrated system will likely be a difficult and lengthy process for existing health care entities and likely require several incremental payments that build off each other. In some cases establishing such contractual relationships and fully aligned payments may not be possible in certain market conditions. Restructuring physician compensation incentives away from volume (i.e. RVUs) could be met with a large amount of resistance. Nevertheless, there are several concrete payment and delivery steps hospitals and EDs can take to optimize episodic, emergent, and acute care while promoting high quality.

Payment Reform

- *Introduce alignment and accountability with shared savings.* Payers and hospitals, as well as hospitals and emergency physicians, can begin to align cost reduction and quality improvement goals by setting total cost and performance thresholds for certain procedures and diagnoses. If the physician, ergo the hospital as well, is able to reduce costs relative to established thresholds, a portion of those savings can return to the physician in terms of salary bonuses and hospital in terms of increased facility fees. Quality measures can be implemented to ensure patient safety and adherence to clinical standards remains unaffected.
- *Increase alignment with elements of partial capitation.* Over time physicians, hospitals, and payers can begin to increase the reward and savings potential by shifting payment out of serviced based arrangements to person and population level payments. These payments can again include elements of shared savings, giving the hospital and physicians clinical flexibility and reward them for efficiency and improved quality. For example, a capitated rate for all outpatient services for a given diagnosis or care coordination, or a population based facilities fee. This will strategically align payers, providers, and entities toward common goals.

Delivery Reforms

- *Work with other health entities to share critical electronic information.* A significant problem many EDs face is lack of information—did the patient already receive this test, what medications are they on, when was the last time a patient was seen by their primary care provider, and so on. Care is highly fragmented and uncoordinated, and data sources are disparate and rarely mutually accessible. Reducing information asymmetry by forming regional partnerships with other health care providers could profoundly change how EDs operate. Health information and data sharing standards would need to be followed, but there are examples of reproducing KP's EHR system for the ED—the Emergency Department Information Exchange (EDIE) in Washington State, for example. Moreover, such initiatives could start with sharing critical data for ED decision making, rather than aiming for full practical interoperability.
- *Develop ED specific pathways and protocols.* Improving throughput and output in the ED represents a significant opportunity for EDs, which are already in high-demand. Implementing pathways and protocols developed by ED physicians, hospitalists and other hospital specialists can more efficiently utilize all team-members, improve outcomes, and decrease workload. Such protocols in the ED have been described as "putting [care] on autopilot" and allowing the physicians to meet volume and provide more safely accurate, patient-centered care.
- *Patient engagement to disrupt ED demand.* It is well-known by hospitals and ED physicians that much of the demand for emergency services is exogenous—outside the control of either party. However, working with health plans and across care providers, both inside and outside the

hospital, to create patient-centered tools could be a worthwhile upfront investment. Although, a system like KP OnCall would require substantial investment, hospitals and EDs should explore partnerships with local practices and medical homes to augment their telephonic "on call" services 24/7, incent primary physicians to provide their patients secure e-mail access, and develop clinical outreach programs for patients at high risk for need of ED/hospital services (e.g. congestive heart failure). This can help pre-empt some of the need for some ED visits, and shift many ED services to more clinically appropriate locations. Hopefully this would relieve some of the increasing demand on EDs, and be greatly appreciated by patients.

ENDNOTES

1. Rosie the Riveter -- World War II Home Front National Historical Park *World War II In the San Francisco Bay Area, A National Register of Historic Places Travel Itinerary* http://www.nps.gov/nr/travel/wwIIbayarea/ros.htm. Accessed April 16, 2015.
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