

# **It Ain't As Easy As it Looks\*: The Translatability and 'Spreadability' of Accountable Care**

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*\*(but it's not impossible, either)*

# East Coast – West Coast Affiliation

- **Perspective : a seeming head start**
- **Kaiser Permanente - West of the Rockies versus “Other”**
- **A California Girl goes East, and lands on Mars**
- **Not so integrated, not so accountable, and far, far away from the medical home**

## 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)**

## 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

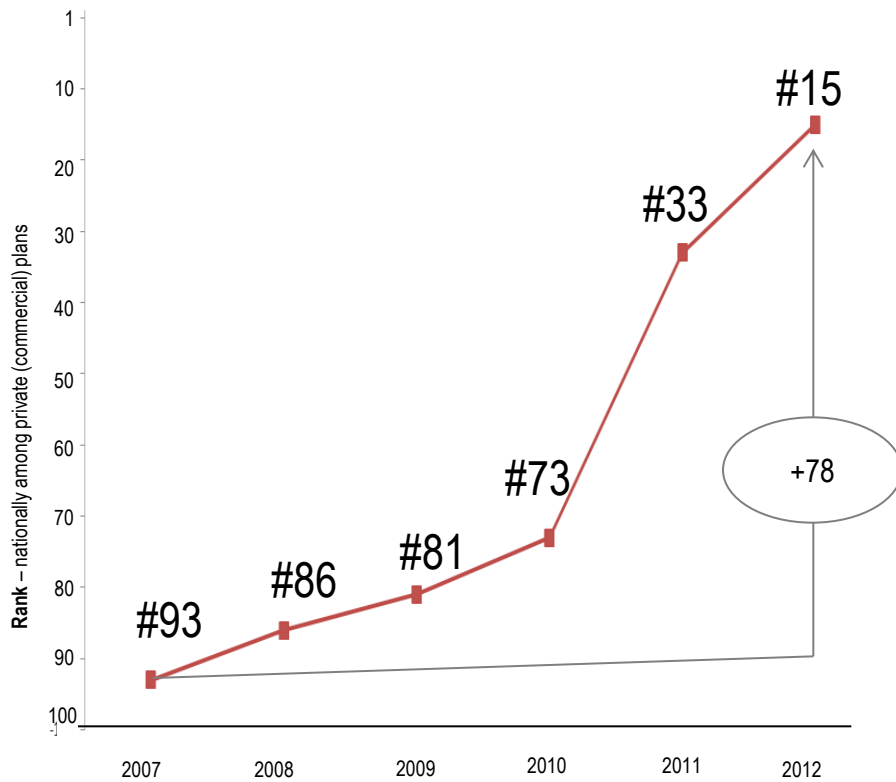
\*\*\* an homage to Dr. Thomas Lee, "Turning Doctors Into Leaders", HBR, March 2010

## Turning It Around: Part 3

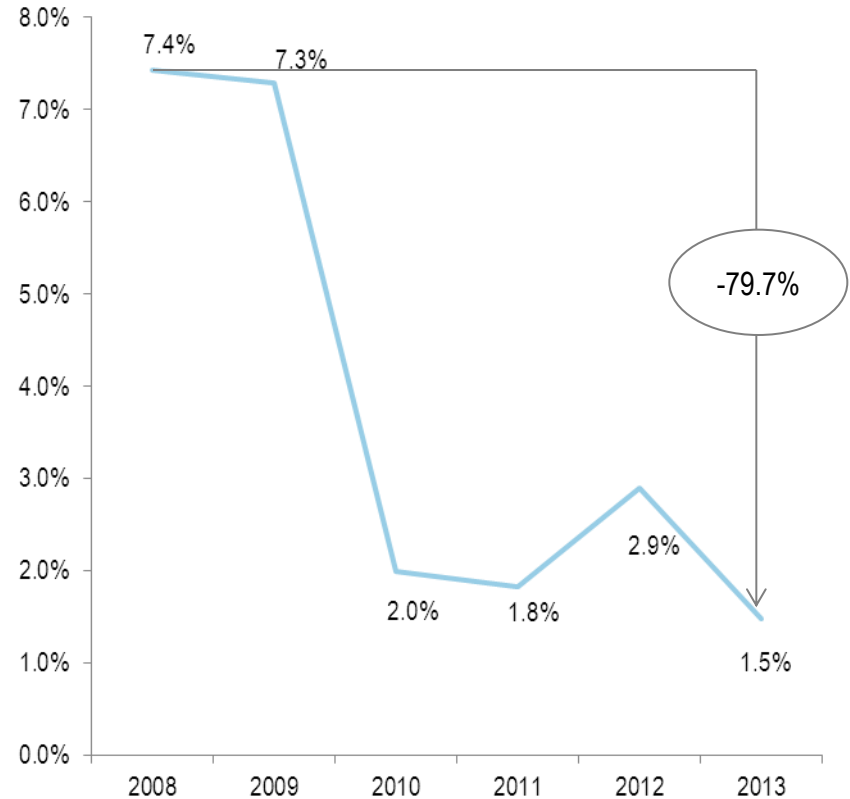
- A re-dedication to “owning” the hospital and post-hospital portion of the continuum
- Systematically redefining relationships with fewer hospitals that are like-minded, and staffing them with our physicians
- General observations on turnaround:
  - ✓ Focus, focus, focus – on execution.
  - ✓ It’s not 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

National Committee for Quality Assurance ranking of health plans in the U.S.; \* Other Large Mid-Atlantic Health Plans listed represent insurance carriers operating in MD, VA, and DC with a minimum of 150,000 commercial members . Source: HealthLeaders July 2011

# Historical KPMAS Membership Annual Growth YOY

## 2001 - 2009

- Average annual membership loss of 8295
- 74660 net loss over 9 years
- 7 of 9 years (78%) were “losing” years

## 2010 – YTD 2013

- Average annual membership gain of 5295
- 18534 net gain over 3.5 years
- 3 of 4 years (75%) are “winning” years



# Critical Lessons (1) for Translatability/Spreadability

*There are some critical IT systems that must exist*

- Under-investment here will be a long-lived handicap

*The hospital partner is critically important: Must have aligned vision/values*

- A looming new business model for hospitals – bed days SHOULD drop in ACO's – how do hospitals “re-set the margin generation thermostat”?
- Inclusion of and alignment of hospital-based/exclusively-contracted professionals in the “mission” of the ACO is essential to improvement in overall cost structure.... the “anesthesiologist in the room”

*Physicians must believe they are practicing a better form of medicine*

- The importance of culture change/development and the role of steadfast leadership cannot be underestimated

# Critical Lessons (2) for Translatability/Spreadability

*Patient acceptance of the model is dependent on them really feeling the value...*

- Access is the rising tide that floats all boats
- Must strive for exceptional patient experience, confidence, and coordination at every visit
- Patient must be able to tell the difference between an un-integrated, and an integrated, care experience. If they can't, then the ACO's not working.
- A longer drive , or a “narrower network” becomes worth it due to a palpably better experience
- “Gotta be the place the patients wanna come...”

## Critical Lesson (3) for Translatability/Spreadability

- A new ACO could be much like the 2009 edition of KP Mid Atlantic – no focused vision of what it wanted to be; few systems; little know-how; and poor or counter-productive culture
- But vision, systems, know-how, and culture improvement can all be obtained/attained, and fairly rapidly so.
- It takes some investment up front; leadership (especially physician leadership); the hard work of implementation; and relentless focus on the end points in care quality, patient experience, and cost efficiency.

# Questions?

