Physician Accountability for the Quality and Cost of Care

Creating a Culture of Accountability
The Permanente Medical Group

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Can Physicians Manage the Quality and Costs of Health Care?

The Story of the Permanente Medical Group

John G. Smillie, M.D.
Organizational design: KP

- Integrated financing and delivery scheme
- Mutual exclusivity, partnership of equals
- **Single funding stream, global budget, explicit accountability for health of defined population**
- **Aligned incentives: prepayment to the Plan, capitation to the Medical Groups; salaried physicians**

Self-governed, Self-managed Medical Group: the strategy

- **Plan delegates, and Medical Group accepts, responsibility for both quality and cost of care**
- **Clinical care, patient satisfaction, resource management, design and operations of delivery system**
But, **culture eats “strategy” for lunch every day.**

- Accountability for the quality and cost of care for each patient as well as the population
- **Stewardship:** responsible fiduciaries of member resources and member health/patient outcomes
- “Righteous work” for a prospectively paid mission-driven organization
- Performance matters: transparent sharing of results internally – unblinded peer performance data
- Broad engagement in “shared accountability” enables preservation of autonomy (“individual accountability”) in the exam room and the bedside
- **Commitment**, rather than compliance, **education** rather than enforcement
- Frontline MD ownership of process and outcomes
Evidence Based Prescribing: Pharmacy and Therapeutics

- Peer clinical experts, using best available evidence (developed by Drug Information Services) review drugs for quality, safety, effectiveness, and (when more than one option) relative cost effectiveness for formulary inclusion
- Broad engagement – more than 1 in 10 physicians involved; process accessible to every physician
- Academic detailing; prescriber support tools; decision support and Best Practice Alerts in EMR
- Unblinded peer performance reports, “pride-based performance”
- **No prior authorization; not linked to coverage**
- **Freedom from industry influence – rigorous conflict of interest policies**
Five Initiatives
Annual cost avoidance: $250,000,000

2005 DRUG Initiative Preferred Agents Rx Market Share vs Community*

<table>
<thead>
<tr>
<th>Category</th>
<th>KP N.Cal</th>
<th>Community*</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2-Antagonists</td>
<td>47%</td>
<td>20%</td>
</tr>
<tr>
<td>HTN</td>
<td>78%</td>
<td>73%</td>
</tr>
<tr>
<td>SSRI-SNRIs</td>
<td>79%</td>
<td>44%</td>
</tr>
<tr>
<td>Statins</td>
<td>94%</td>
<td>25%</td>
</tr>
<tr>
<td>NSAIDs vs Cox-2s</td>
<td>99%</td>
<td>9%</td>
</tr>
</tbody>
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*MedImpact Book of Business
Savings Opportunities - 2007

- **Lipid Lowering Drugs**
  - US spending $18.3 billion
  - Hypothetical KP equiv. use $6.7 billion

- **PPIs**
  - US spending $14.1 billion
  - KP hypo. $3.3 billion

- **Antipsychotics**
  - US spending $13.1 billion
  - KP hypo. $5.1 billion

- **Antidepressants**
  - US spending $11.9 billion
  - KP hypo. $4.3 billion

- **Seizure medications**
  - US spending $10.2 billion
  - KP hypo. $5.3 billion

- **Total difference** $42.8 billion (5 classes)
Overall Cardiovascular Mortality

Spectrum of Cardiac Care

Trends in Heart Disease Mortality in the population of Kaiser Permanente (N. California) and the rest of California, age-sex adjusted*, 1995-2004

* 2004 KP is the standard pop for the adjustment
Coronary Procedures – PCIs, CABG, CATH

National 50th Percentile Rate  Kaiser Permanente Rate

Procedures/ Thousand Males aged 45-64

2006 Data

PCI  CABG  CATH  PCI  CABG  CATH

8.2  2.4  12.3  4.8  1.7  4.4
Delivering Results – Cultural Levers

- Physician leadership – visible, vocal, unwavering
- Broad ownership and engagement in the process of goal setting
- Respected clinician champions willing to lead, engage with peers
- Actionable metrics – “revealing reports” and “data that drives” performance
- Timely reporting and feedback
- Unblinded data sharing; identification of successful practice
- Recognition and celebration of success – “Pride 4 Performance”
- Results- quality, health outcomes and efficiency- reinforce culture of performance, accountability and pride; requires “maintenance of effort”
Practice of Medicine in Permanente is Built on a Foundation of Accountability

**Processes and Infrastructures**

- Transparency in Performance and Practice
- Evidence-Based Processes
- Clinical Information Systems
- Team-Based Care
- Quality Improvement Structure
- Resource Efficiency
- Shared Decision Making
- Patient Involvement

**Organizational Characteristics**

- Commitment to Quality
- Ethical Compensation
- Group Responsibility and Stewardship
- Multispecialty Group Practice
- Physician Self-Governance and Self-Management

**Measurable Objectives of Value**

- Clinical Outcomes
- Patient Satisfaction
- Preventive and Wellness
- Physician and Staff Satisfaction
- Safe Care
- Cost Effectiveness
- Timely Access to Appropriate Care

Practice of Medicine in Permanente is Built on a Foundation of Accountability

Physician Self-Governance and Self-Management