By Rob Ryan, MD

Primary Care Redesign

*F*or the past several years, Kaiser Permanente has been fundamentally redesigning primary care delivery in Georgia. We have built a unique model centered on physician ownership and accountability along with incentives and compensation levels which are tied to performance and member satisfaction. Structured around small, semi-autonomous teams, this model blends the best of two worlds by leveraging the scale, structure, experience, and reputation of the nation's largest and most respected health maintenance organization (HMO) to create and support small teams of medical professionals who manage the care of a defined panel of patients.

Introduction: The Challenge

Kaiser Permanente in Atlanta, Georgia (KP-Atlanta) began operations in 1985, and by 1992 there were more than 156,000 members enrolled. The plan had accumulated operating debt of approximately $80 million at a time when competition was intensifying. A 1993 study showed that our internal cost for delivering primary care was about 40% higher than in community practice. Our competition was delivering primary care much more efficiently, and our predictions suggested that our price disadvantage would increase.

### The Primary Care Redesign Model

To meet these challenges, in 1993 KP-Atlanta developed a turnaround plan which focused on three building blocks of successful prepaid group practice: open access to care, increased productivity, and a physician workday policy which defined a minimum number of hours per day which each full-time physician or associate provider (nurse practitioner or physician assistant) would devote to providing direct ambulatory patient care.

A fundamental component of this turnaround plan was major redesign of primary care centered around development of health care teams. Although the initial intent was to find new efficient methods of delivery, perhaps even more important was that this redesign ultimately became a vehicle to improve patient satisfaction and to make market-leading quality improvements.

After about a year of assessment and design, in 1995 we implemented a 6-month pilot program at one of our facilities, followed by implementation of the program at our nine medical facilities over the next 18 months. Throughout the implementation process and at every operational level, all physicians or other employees were required to reapply for posi-

The Health Care Team (HCT)

10,000 members/11-person HCT
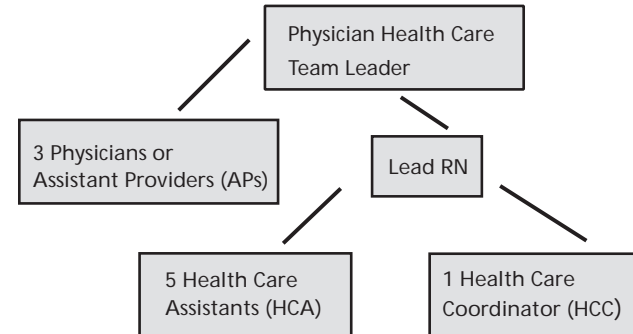
Key assumptions for HCT success:
- Facility opens 8:30 am - 6:00 pm Monday through Friday, 261 days per year
- The HCT sees, on average, 100 patients per day and advises by phone 22-25 patients per day
- MDs see 40% of patients, corresponding in the higher acuity cases
- MDs average about 30% more time per patient than APs
- HCT is managed by a Health Care Team Leader
- HCT is a semi-autonomous work group responsible for quality of care, member satisfaction, provider access, and concern resolution
- Each HCT is capitated for membership's direct costs only—personnel payroll and nonpayroll
- Gain share is produced by membership growth or more effective use of personnel and nonpayroll

Fig. 1.

tions on the team and to participate in a behavioral interview. In behavioral interviewing, applicants are asked to give specific examples of their past experiences which would show high probability of possessing skills necessary in their positions. For instance, all health care team leaders and facility managers were interviewed and were evaluated for skills in leadership, coping, and making decisions.

Our next step before further implementation was to install the leadership positions—facility managers and health care team leaders. First, for each facility we selected management teams consisting of a physician-manager and a medical center administrator. We made it clear that all facility managers were required to reapply for their old jobs without any guarantee of reappointment. The primary competency requirement for these middle managers changed from direct line management to coaching and mentoring health care teams to support their increasing autonomy. Next, senior managers and these facility managers participated in behavioral

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ROB RYAN, MD, is the Associate Medical Director and Chief Operating Officer for The Southeast Permanente Medical Group, Inc.

interviewing of applicants for the 24 physician health care team leader positions, during which time they were asked specific behavioral questions about management skills believed to be important in managing the new teams. After the health care team leaders were in place, they in turn initiated a selection process for their lead nurses by soliciting applicants for these positions. The positions prompted a high level of competition, and many nurses were willing to change facilities to become lead nurses. After being chosen, the lead nurses and health care team leaders posted the positions for providers and other team employees. Again, multiple applicants were considered for every position, and only the most suitable were chosen.

Training of our teams was very detailed during implementation of the program, which occupied eight full days for each team. Teams were therefore unavailable to provide patient care during the training period.

This entire implementation process took place throughout KP-Atlanta in 1996, and all health care teams were in place by the beginning of 1997. Throughout 1997 and 1998 we expect to continue implementing major pieces of the primary care redesign, including introduction of more advanced technology and new compensation systems.

The Health Care Team

A team-based approach to primary care is at the core of our primary care redesign and is embodied by health care teams (Fig. 1). All 24 teams are led by a physician who is accountable for the team's budget and overall operations. Although a team staffing model was developed, in reality we allow each health care team leader to determine makeup of the team as long as the team stays within budget. Team members center their duties around caring for the panel of patients assigned to the team. This panel concept

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facilitates population management, and we expect that by providing personal and satisfying care, our teams will "grow" their own membership as part of their business strategy.

How does a fee-for-service practice expand its business? Stated differently, why grow a practice? We want the same outside community economic issues to affect each health care team. Specifically, a team can increase its revenue by increasing the number of patients on its panel. Issues of revenue appropriation (e.g., determining number and combination of providers, nurses, or other employees or nurses which will make up the team) will be decided at the health care team level. In addition, compensation arrangements will allow incentives to be offered for the team to optimize productivity and will no longer impose divisional directives in areas such as patient scheduling.

For our patients, value is created at the team level, and our new health care teams will not succeed unless they continue to provide highly personal, accessible care which produces defined, measurable, high-quality outcome. In the past, KP-Atlanta improved access to care by initiating a work policy which required all physicians and associate care givers to provide direct patient care for at least the defined minimum number of hours daily. In the future, each health care team will define the time and modality of care needed to meet the demands of each team's panel of patients. The health care teams become successful by increasing the number of members assigned to their team and then providing satisfying care to these members. The divisional administration is developing the skills necessary to measure the outcomes and patient satisfaction and to use the results to measure success of the health care teams. Each team will be given this information to aid in evaluating its own performance.

Technological Support

Throughout KP-Atlanta, electronic medical recordkeeping (Fig. 2) is a high-priority goal which, when achieved, will greatly assist in managing each health care team's panel of patients. The plan is to introduce a pilot version of the electronic medical record in 1998 with full implementation regionwide pending results of the pilot. The electronic medical record will be integrated into the laboratory, pharmacy, and radiology department systems, the referral system, and a new physician profiling system. The profiling system will allow us to more accurately determine acuity and panel size for each health care team. Although the technology will mainly facilitate medical care provided by our health care teams, it will also aid in measuring team performance when
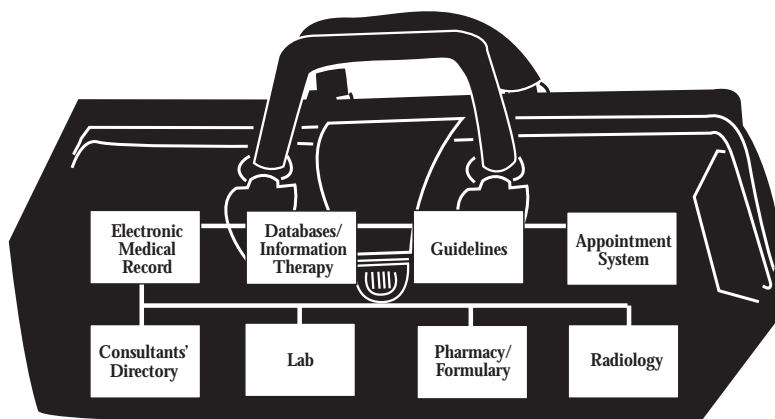
Fig. 2. The electronic black bag of the future.

evaluating in the health care teams. These new forms of technology can measure both cost and quality of performance.

Telemedicine

The ability to provide daytime advice by telephone is incorporated into the health care teams; after hours, advice is provided by a regional call center, a leveraged service started in 1996 which is also a centralized provider of appointments.

Telemedicine expands patients' access to care while improving efficiency at the health care team level. A study clearly showed that our patients responded positively to being given an appropriate appointment by telephone. Since then, we have encouraged our health care teams to schedule telephone appointments; currently, most are doing so at a rate of about two appointments per session with a patient. We envision many health care teams expanding the use of the telephone appointment to provide efficient care to its panel of patients.

Complete, Integrated Care

As mentioned, our health care teams are encouraged to take responsibility for the panel of patients assigned to them. We expect the health care teams to involve patients as much as possible in their own health care decisions. This kind of care should become more personal, more realistic, and rely less on referrals. For our patients, this style of practice should create real value: care becomes less fragmented and more personal, and the health care team assumes clear-cut accountability for its performance. This concept represents the new frontier of health care delivery, and education of our primary care providers is its cornerstone. Physicians practicing both in primary care and in specialty areas have created and agreed upon clinical guidelines whose appropriate use can be measured in ascertaining the health care team's success.

Disease Prevention and Early Intervention

The primary care redesign model emphasizes disease prevention, early intervention, and disease management by each health care team. Accordingly, health care team training emphasized disease prevention and early intervention as well as other elements of the team's duties: Prevention programs such as for smoking cessation, breast cancer screening, management of acute low back pain, and ensuring child immunization were discussed in detail. Each health care team was trained in member communication and follow-up procedures specific to the identified intervention programs. We expect that in the future, incentive programs for health care teams will be aligned around accomplishing certain prevention and early intervention goals.

Budgets and Incentive Programs

Each health care team's budget is capitated and allows for capitation surplus to be gain-shared (Fig. 3). Total compensation is linked to patient satisfaction and to quality of outcome. This arrangement encourages increase in size of the team's patient panel while ensuring high-quality performance and increasing patient satisfaction. The Board of Directors for The Southeast Permanente Medical Group has recommended adding a flexible component to the standard salary system which would allow a portion of each provider's compensation to be flexibly distributed according to productivity, patient satisfaction, and quality of service, with each service setting its own performance measurements. Because each physician health care team leader must understand the business principles involved in compensation and in capitation, practice consultants have been hired to work with these physicians to expand their knowledge of budgeting, capitation, and general office efficiency. Most of the 24 physician-leaders are inexperienced in this area, so we have embarked on a rigorous management training program for all of them. Certainly not all physicians are natural entrepreneurs, and part of the challenge is to create sufficient knowledge of good business practices at the health care team level.

New Management Structure

During the redesign process, we realized that the traditional Kaiser Permanente management structure would not support this future model; for this reason, a new management structure was created specifically to support the concept of semiautonomous health

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Overview of Primary Care Redesign

Capitation:

Per Member Per Month (PMPM)

→ Savings generated gain share

Bonus:
- Quality
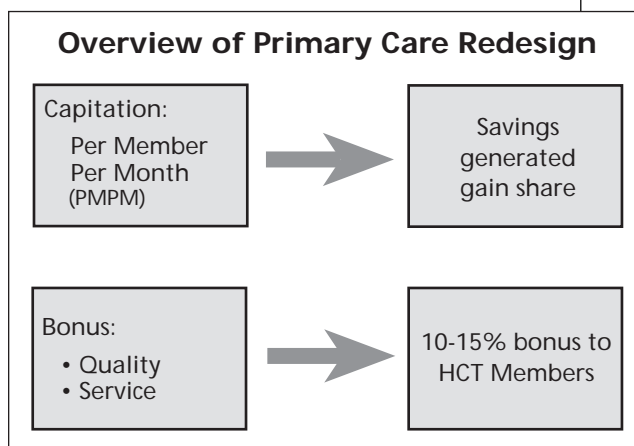- Service

→ 10-15% bonus to HCT Members

Fig. 3.

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care teams. This management structure supports and fosters physician ownership and team accountability for high-quality health care, patient satisfaction, and office efficiency. As mentioned, each health care team is led by one physician to whom the team's other physicians, providers, and personnel report.

Middle management at the facility level has also experienced an important change as mentioned, with its primary responsibility being to mentor and facilitate development of each health care team. Success of these managers will be measured by success of the health care teams in their facilities.

At the senior level, an associate medical director for primary care has been established to oversee the entire primary care redesign and its implementation.

Summary

We have created a model of health care delivery which emphasizes physician ownership and accountability. Empowerment and innovation have been encouraged while maintaining Kaiser Permanente's long-standing value to the community. Each health care team has been encouraged to become a semiautonomous business unit making its own decisions about how care is delivered to its patients. Concurrently, the regional adminis-

tration is improving its evaluation of team performance, patient satisfaction, and quality. Ultimately, such evaluation should enable each team to align its compensation system toward persons or groups on the team who show the highest levels of quality, satisfaction, and efficiency.

The overall impact of our primary care model design has been profound. Clear accountability at the health care team level—most specifically, accountability of the physician health care team leader—has created an atmosphere of physician ownership and accountability not seen before in KP-Atlanta.

Although health care teams are now in place throughout KP-Atlanta's nine medical centers, the primary care redesign effort is far from complete. Computerized medical recordkeeping and other technological initiatives are yet to be fully implemented. However, even more important is the transition we can only term "cultural change," which we have found to be a slow, step-by-step process. The challenge has been to focus on the end state: a delivery system where quality is improved and patients are cared for efficiently in a service-oriented, member-friendly way. With such a system in place in Georgia, Kaiser Permanente will be ready to meet the health care challenges of the future. ❖

"Before people will accept a new idea, they will do everything in their power to integrate it into the old way of thinking."
Margaret Wheatly, Leadership and The New Science