Strengthening Primary Care for Patients:

Hawaii Permanente Medical Group | Honolulu, Hawaii

Kaiser Permanente is an integrated care delivery organization that provides care for over 9 million members across nine states and the District of Columbia. The responsibility of design, implementation and optimization of care delivery lies with the regional Permanente Medical Groups, while reimbursement is paid via the associated Kaiser Foundation Health Plan.

Initiative Title: Patient-Centered Medical Home
Start Date: 2008
Practices: 16 Outpatient Clinics
Physicians: 128
Covered Lives: 226,000

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care.

The community-based and regional health plans and provider organizations from across the country that make up ACHP's membership provide coverage and care for approximately 16 million Americans. These 22 organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and the quality of care, including patient care coordination, patient-centered medical homes, accountable health care delivery and use of information technology.

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Background

The Hawaii Permanente Medical Group (HPMG) serves over 226,000 individuals throughout Hawaii. Like other regional Permanente groups, HPMG receives reimbursement through its affiliation with the Kaiser Foundation Health Plan.

HPMG staff initially began patient-centered medical home (PCMH) transformation after reading an increasing amount of literature describing the new model of care and realizing that the medical group's existing processes were already very similar to the National Committee for Quality Assurance (NCQA) standards.

For HPMG, PCMH transformation did not require a significant change in its philosophy of how to deliver care, but it was seen as a way to better formalize and systematize the standards that had already been implemented, as well as improve communication across the medical group. As Nathan Fujimoto, M.D., a physician leader for Kaiser Permanente Hawaii's PCMH effort, said:

> We had kind of lost sight of looking at the big picture. We may have been doing [PCMH processes], but we weren't documenting it, or in some cases, we weren't doing a consistently good job.[1]

The two main goals of HPMG's PCMH project included standardizing the roles of medical assistants and nurses, specifically with respect to care coordination and education outreach, and improving the quality, safety and accessibility of its clinics. While NCQA accreditation was one of the impetuses of the PCMH initiative, medical group leadership considered accreditation as a template rather than an

absolute goal. NCQA provided guidelines and criteria, but specifics of implementation were up to each individual clinic.

Implementation

In April 2004, HPMG implemented an electronic medical record (EMR) system and, later that year, instituted panel management across its clinics. Panel management, which is described in greater detail in the Kaiser Permanente Colorado profile, is a way to proactively identify patients who need medications, testing or other evidence-based care, and then use a variety of outreach methods to offer them care. With respect to improving care quality and reducing care gaps, most practices spotlighted diabetes management and the reduction of uncontrolled $HbA1_c$ values.

HPMG began having more formal discussions related to primary care redesign in 2008; its PCMH initiative was approved by HPMG and health plan clinic leadership structure, and both groups participated in discussion, approval, rollout and implementation. In April 2010, HPMG began to push for NCQA recognition and the first HPMG-affiliated pilot practice received NCQA Level III recognition in October 2010. Since then, all 16 primary care sites have achieved Level III recognition.

During the initial planning phases at each clinic, HPMG leaders coordinated regularly scheduled meetings that brought together clinical and administrative representatives from each site in order to create a balanced group capable of directing and managing change. During these meetings, individuals completed self-assessments on behalf of their practices, which helped reveal areas that needed to be focused on during medical home transformation.

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After completing the preliminary self-assessment, practices were given the option of engaging Process Excellence (Lean) leaders, who were tasked with facilitating bimonthly practice-level assessments and assisting practices with the formation of customized implementation plans. Practice leaders were given specialized training and had access to a wealth of resources including change management and Lean consultants, as well as individuals throughout the Kaiser Permanente network who had experience with PCMH transformation.

To guide process improvement, HPMG provided monthly dashboards to the practices that included HEDIS® outcomes, patient satisfaction measures (such as average speed to answer phone calls or the percentage of continuity per visit between primary care physician and patient) and cost trending data (including admission, readmission and emergency department utilization rates).

Self-Management

One focus of PCMH transformation work was increasing communication and health education outreach to improve individuals' ability to self-manage illness. HPMG staff members began using the electronic registry to determine whether patients' conditions were being managed well and communicate what patients could do to improve their health.

In order to increase patient education, many practices developed outreach programs to educate members on the importance of controlling their conditions, which patients could access through group visits and telephone or e-mail consultations. HPMG also created patient testimonial videos, which helped members understand how self-care can be beneficial and worthwhile, framed in a relatable perspective.

Transitions of Care

The medical group had just begun working on transitions of care when it started its PCMH initiative; as part of the NCQA certification process, HPMG implemented post-hospital and post-emergency department visit phone calls to patients. It has now spread those practices and begun increasing cooperation and coordination between patients, physicians, disease managers and care coordinators, as patients transition from hospital care to either home care or sub-acute care.

For example, HPMG brought home-care agencies onto the clinic team and developed collaborative case management, including medication reconciliation and follow-up phone calls. Currently, all nurses can see each other's notes and access real-time care plans and information on which nurses are attending to which patients; they can also send electronic messages to each other to better coordinate care during transitions.

HPMG is working with hospitals to determine process and outcomes metrics for measuring the success of the transitions initiative and is benchmarking readmission rates for Kaiser Permanente Hawaii hospitals. One initiative the medical group has implemented with hospitals involves segmenting patients based on risk of readmission upon discharge, and sharing those reports with primary care nursing supervisors. The nursing supervisors then follow up with the nurses providing the care in order to encourage alignment between care teams.

Other Initiatives

HPMG has launched an initiative around pediatric care, particularly pediatric obesity, with a focus on patient activation and empowerment and encouragement of family-based care. A HPMG work group is examining and standardizing processes for care teams, which include physicians as well as ancillary support. The medical group is also identifying high-risk patients for care management based not on specific disease states, but on general rates of utilization.

Coordination across Regions

The health plan program office helps coordinate initiatives among all Kaiser Permanente regions by sponsoring a yearly meeting. In addition, the regions meet monthly to discuss their initiatives and compare performance, and engage through informal partnerships. Kaiser Permanente Hawaii receives monthly emails about best practices from other regions and participates in reward and recognition programs that publicize certain practices. All regions are aligned to the same outcome metrics to more easily compare performance.

Sustainability

Kaiser Permanente Hawaii is unique in that each clinic has teams comprising physicians as chiefs of clinics partnering with nursing/business supervisors to lead operations and implement changes. This balance of clinical and operations support enables HPMG to adopt processes to meet the needs of both areas. This partnership is strengthened and reinforced through regular meetings that create structure and reinforce operations.

The medical group is increasing the standardization of protocols and care processes for all team members. By standardizing protocols and care processes, which has improved HEDIS® measures and met patient needs in areas where it had struggled previously, such as immunizations, screenings and diabetes control. There is now more consistency in terms of what care staff members are assessing and teaching, including an increase in evidence-based medicine, based on results from published literature.

From the outset, HPMG has acknowledged concerns about standardization infringing on providers' independence; in response, the medical group has attempted to influence established norms by making population management easier for practitioners.

One benefit of Kaiser Permanente Hawaii's relatively small size is its nimbleness. The plan and medical group have the freedom and ability to make changes from month to month and week to week, and HPMG can quickly adopt best practices that have been vetted in larger systems, adapting them to the Hawaii region. Because Hawaii is isolated geographically, relationships between providers have been developing over many years, and cooperation is a necessity.

Outcomes

The guiding framework for measurement at HPMG practices was the Triple Aim of decreased costs, increased quality of care and enhanced patient satisfaction. The medical group also measured service-based metrics daily, which were reported on monthly. Those metrics included the average speed to answer phones, abandoned call rates, physician percentage of panel touches, continuity percentage between members and their panel physician and patient satisfaction.

Over four years, HPMG improved its scores on disease management, LDL cholesterol level, blood pressure control and breast cancer screening HEDIS® measures from the 50th to the 90th percentile. Improvement was also noted in the percentage of diabetic patients able to decrease their $HbA1_c$ below 9 percent. Attribution for outcome improvements, however, has been difficult since many of the processes measured during the initiative were already built into the system.

The practice has reported consistently high levels (greater than 90 percent) of patient and provider satisfaction and a less than 5 percent call abandonment rate as of 2009. In 2012, the medical group received a five-star Medicare rating from the Centers for Medicare & Medicaid Services.

Scale

While the Kaiser Permanente Hawaii Kai clinic was the first NCQA PCMH-certified site, the model has since been modified and spread to every clinic in the region, all of which were individually NCQA PCMH certified. HPMG is due to recertify its practices in 2013.

HPMG was cautious not to set rigid deadlines during the spread of the medical home model; practices were encouraged to follow their self-assessments and make only those changes that they were realistically capable of taking on. Some practices chose to implement all changes required for NCQA certification at once, while other practices chose to prioritize and make gradual changes. The endpoint for the pilot was flexible, in that practices were advised to submit their paperwork for NCQA accreditation at whatever point they felt they had met 100 percent of the NCQA objectives.

The medical group notes that data outcomes reported by early PCMH innovators have been encouraging. As Dr. Fujimoto stated, "For us, the model that we have [is] really good because it has been validated and we feel strongly that we're on the right track."[2] HPMG leaders note that in the coming years they plan to do more than just sustain the changes: "It's about continually trying to improve, that's the perception that leadership has, and I think that we'll continue to embrace that."

A copy of the full ACHP report on strengthening primary care for patients, supplementary profiles on member plan initiatives, a one-page fact sheet and other resources are available online at www.achp.org or by emailing innovations@achp.org.

[1] Participant interview with ACHP, 2012
[2] Participant interview with Rebecca Malouin, Ph.D., 2011

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