Kaiser Permanente: An Integrated Health Care Experience

By Molly Porter and Meg Kellogg

Kaiser Permanente as a Leader

Kaiser Permanente (KP) is the largest nonprofit, nongovernmental, integrated health care delivery system in the United States. It operates in nine states and the District of Columbia and has 8.7 million members, 14,000 doctors, and 160,000 employees. About three-quarters of these members and employees reside in California, where the company began in 1945 and has its headquarters. The Program owns and runs 421 medical office buildings (for ambulatory care only) and 32 medical centers (hospitals with ambulatory care).

In California, the medical centers offer "one-stop shopping" for most services: hospital, outpatient offices, pharmacy, radiology, laboratory, surgery and other procedures, and health education centers. This co-location is a straightforward mechanism for integration. It encourages patient compliance and enhances opportunities for primary care physicians to communicate and consult with specialists, hospitalists, pharmacists, etc.

Kaiser Permanente is widely recognized as a leader in health care. It is the only California health plan to have appeared 11 years in a row on the annual list of best health plans in the Pacific Region by an outside accrediting agency – the National Committee for Quality Assurance (NCQA). U.S. News and World Report ranked it as California's best in 2005, 2006, and 2007, and the New York Times published an article about it in 2004 that said:

"Quality health care in America will never be cheap, but Kaiser probably does it better than anywhere else. According to economists and medical experts, Kaiser is a leader in the drive both to increase the quality of care and to spend health care dollars more wisely, using technology and incentives tailored to those goals."

Our Numbers

- 8 regions serving 9 states and the District of Columbia
- 8.7 million members
- 14,000 physicians
- 160,000 employees (including 41,000 nurses)
- 32 medical centers (with hospitals)
- 421 medical office buildings
- $38 billion operating revenue (2007)

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As an example, NCQA singled out Kaiser Permanente's Northern California Region for its cardiovascular mortality rate being 30% lower than the community. That means people who belong to Kaiser Permanente in this area have almost a third lower risk of dying from heart disease than people who belong to other health plans!

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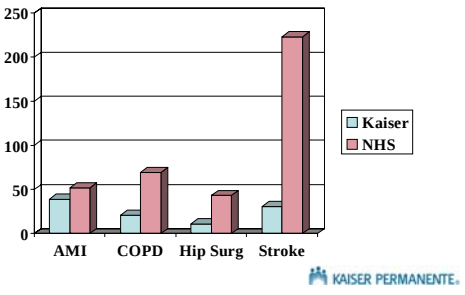
In January 2002, the British Medical Journal published a comparison of Kaiser Permanente in California and the British National Health Service (NHS). The study authors were Richard Feachem, Neelam Sekhri, and Karen White. Among the striking results:

- KP members experience more convenient and comprehensive primary care services and more rapid access to specialist services and hospital admissions than the British NHS.
- Age-adjusted acute hospitalization rates in KP are a third of those in the NHS, while overall performance is better.
- KP does this through more efficient use of hospitals, integration, and use of information systems.

Below you'll see the comparative rates of hospital utilization between Kaiser Permanente and the British National Health Service for four conditions:

1. Acute myocardial infarction (AMI or heart attack)
2. Chronic obstructive pulmonary disease (COPD)
3. Hip surgery
4. Stroke

Hospital Utilization: Days/1000



This study was widely discussed and disputed, so follow-up studies were conducted in 2003 and 2005 that confirmed the results. As a result, the British NHS began developing what they called "Kaiser Beacon sites" that adapted aspects of Kaiser Permanente's integrated care model. These sites are located in Northumbria, Eastern Birmingham and Solihull, and Torbay. They have focused particularly on care for people with long-term conditions with the aim of improving quality of care and reducing inappropriate hospital use.

Kaiser Permanente's Mission

Kaiser Permanente's mission is "to provide high-quality health care to our members and patients and to improve the health status of the communities we serve." As a nonprofit health plan, it doesn't pay taxes but instead commits a sizable portion of its net income (about half) to a Community Benefit program devoted to the following activities:

- Charitable Care and Coverage (to help those who can't afford it pay for Kaiser Permanente health insurance)
- Safety Net Partnerships (to help finance other organizations that help serve the uninsured, such as community clinics and public hospitals)
- Community Health Initiatives (addressing America's obesity epidemic through public policy activity and a Healthy Eating/Active Living partnership with community organizations)
- Developing and Disseminating Knowledge (funding and disseminating health care research and evaluation studies and sharing Kaiser Permanente's best practices)

Kaiser Permanente's History

The origins of Kaiser Permanente date back to 1933 on the Mojave Desert in California, where workers were building an aqueduct in a remote location and had little access to health care. The employer hired Dr. Sidney Garfield to provide medical care to his workers on a fee-for-service basis. The problem was that the workers often couldn't afford to pay for injuries or illnesses that weren't job-related, and if they were seriously injured on the job they were sent by the insurance companies to doctors and hospitals in the Los Angeles area. Dr. Garfield was about to go bankrupt when he and an insurance company executive came up with an idea: Instead of charging on a

fee-for-service basis, they deducted a small amount every week from the workers' paychecks as a prepayment for all health care services.

This idea of prepayment transformed the way Dr. Garfield thought about medical care. Since there were no financial barriers to care, the workers would see him before their colds became pneumonia and he could educate them about how to take care of themselves. Legend has it that he went around the worksite hammering down nails and looking for other worksite hazards so the workers wouldn't get puncture wounds and develop tetanus. Once the economic incentives were changed from fee-for-service to prepayment, Dr. Garfield's incentives were changed from treating illness and injury to preventing them. These incentives continue today and are at the root of Kaiser Permanente's reputation for effective self-care and health promotion.

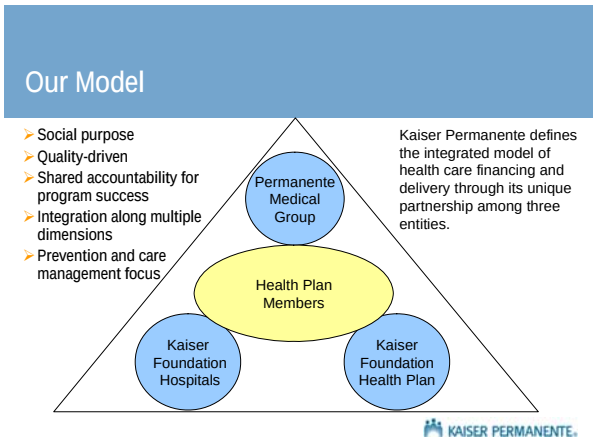
Henry Kaiser and his son Edgar heard about this successful experiment on the Mojave Desert and asked Dr. Garfield to set up a similar plan for thousands of workers on the Grand Coulee Dam project in Washington state in the late 1930s, and then for shipyard workers and their families in California and Washington state during World War II.

When World War II ended, the shipyard workers did not want to lose the health plan that had taken such good care of them at an affordable, prepaid price. Their labor unions asked that the plan be opened to the public so they could continue with it. As a result, Kaiser Permanente opened to the public in 1945.

Organizational Structure and Decision Making

Kaiser Permanente is not an actual legal entity but is rather an umbrella name for three entities that operate in an integrated fashion.

- Kaiser Foundation Health Plan (the insurance arm of Kaiser Permanente, which collects dues from Health Plan members, often through their employers or from the government)
- Permanente Medical Groups (eight of them operate in Kaiser Permanente's eight regions, and they each receive a fixed amount from Kaiser Foundation Health Plan to deliver outpatient care, based on a per-member, per-month basis)
- Kaiser Foundation Hospitals (which operates the hospitals and is also funded by Kaiser Foundation Health Plan).



Mutual exclusivity is a key feature underpinning these relationships. This means that the Permanente Medical Groups do not practice medicine outside of Kaiser Permanente. Similarly, Kaiser Foundation Health Plan does not directly contract with other medical groups. Contracting for needed medical services is done by the medical groups or at a minimum involves their clinical assessment. The incentives of the Health Plan and the physician groups can thus be aligned. In brief, they share incentives to keep the members healthy and the costs of care in line and they both have a shared accountability for the program's success.

Kaiser Permanente owns and operates its own hospitals in California, Oregon, and Hawaii. In other regions – and even within these three regions for some services – it contracts with community hospitals to care for Kaiser Permanente members.

Since 1997, Kaiser Permanente has had another entity at the national level, The Permanente Federation, which serves as an umbrella for the eight Permanente Medical Groups on collective projects such as care guidelines and quality measurement and management issues. The Executive Director is ap-

pointed by an Executive Committee of a subset of the medical group Chief Executive Officers.

Leadership group structures typically comprise both health plan and physician leaders. A decision-making body called the Kaiser Permanente Program Group includes the Chief Executive Officer and Chairman of the Board of Kaiser Foundation Health Plan and Hospitals George Halvorson, the physician Executive Director of The Permanente Federation Jack Cochran, MD, and approximately 10 health plan and physician leaders. This is the highest-level group that considers issues for the combined entities.

This consensus partnership model is echoed in each Region. A Regional President and a Medical Group Chief Executive Officer (elected by the Medical Group) govern the Region together. This is further echoed by medical-management partnerships at the service delivery level, per designated geographic area.

A national Board of Directors legally governs the Kaiser Foundation Health Plan and Hospital organizations. This is made up primarily of outside directors with expertise in various areas from around the United States. All are KP members and reside in KP service areas. Other members are also involved formally through advisory groups or informally through quality improvement programs.

With the prepaid amount that the Permanente Medical Groups receive from Kaiser Foundation Health Plan to deliver outpatient care, they pay their doctors market-based salaries and – if the program is successful and the doctors perform well – bonuses of up to 10% of their salaries. These bonuses are based on quality, access, and service measures. In the last 10 years, the Medical Groups have become increasingly comfortable with transparency of data within their groups – comparing the results of individual doctors, departments, and medical centers in order to learn and improve.

KP has always been proud of the fact that doctors and other health care providers make clinical decisions and the Health Plan doesn't. Joint committees advise on decisions in areas of mutual concern, such as benefit package design and large technology decisions. Physicians have advocated for a comprehensive benefit package when the market allows, since this allows them to more easily coordinate an individual's care. When contracting out is needed, both medical group and Kaiser Foundation Hospital staff tend to be involved in the assessment of outside care.

An additional partnership organization exists that is unique enough to mention. In 1997, after years of periodically tumultuous bargaining relationships, KP and its labor unions created a Labor-Management Partnership with Health Plan, physicians, and KP employee representatives. The partnership was ratified by 26 unions. This group is designed to increase the alignment of incentives through increased communication and collaboration for joint long-term benefit. One of their recent emphases has been promoting health care teams. Its stated seven objectives are: 1) Improve quality of health care; 2) Achieve market-leading performance; 3) Expand membership; 4) Make KP a better place to work; 5) Provide employment and income security; 6) Engage employees and their unions in decision-making; and 6) Collaborate on public policy issues.

Information Technology

Kaiser Permanente has long been a leader in information technology, using computers in innovative ways for decades. Since 2003, it has embarked on a journey to become the worldwide leader in information technology by fully integrating its systems and giving members access to many online features. It has implemented Kaiser Permanente HealthConnect, a secure nationwide electronic data system that links all aspects of the care experience.

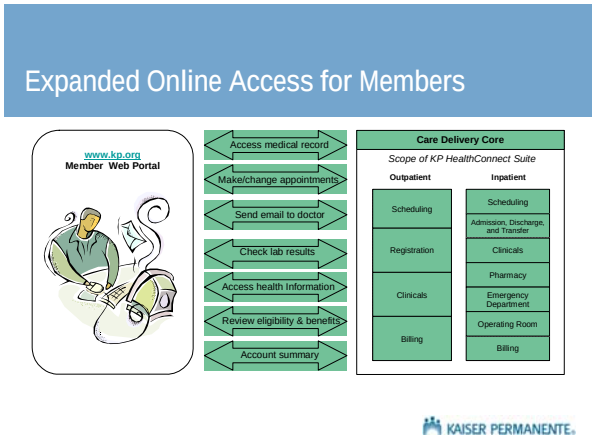
There are many ways in which KP HealthConnect enhances integration of care and provides the promise of more cost-effective, better quality care.

For providers, the system: 1) Becomes the communication and messaging tool among those taking care of patients, ordering tests or medications, and re-

ceiving results. The information is readily available when anyone has contact with the patient. 2) Incorporates decision-support tools, such as practice guidelines, recommended drugs, and alerts for overdue tests or preventive screenings. 3) Offers population management tools such as registries for people with diabetes, asthma, and heart disease. 4) Provides sophisticated information for research and measurement, including feedback to individual practitioners and teams.

Meanwhile, KP HealthConnect offers members and patients: 1) online access to their medical records and test results, health education information, appointments, prescription refills, and even eligibility and benefit information; 2) the opportunity to e-mail their physician; 3) online health assessments and personalized health information tailored to their individual health status.

As of July 2008, all Kaiser Permanente ambulatory care facilities had completed the implementation of KP HealthConnect and nearly half its hospitals were fully electronic – with the other half expected to finish within a year or so. All Kaiser Permanente physicians were using computers in their exam rooms and offices, and about 30% of Kaiser Permanente members had requested a password and were using the protected features of kp.org, such as e-mailing their doctor or accessing their medical records.



KP has learned a great deal about implementing information technology, such as the importance of backfilling for health care providers who are new on the system. The same degree of productivity can not be maintained while people are in the initial learning stages of a new computer system. However, once health care providers have learned the system, they find that they can be equally productive while delivering improved quality of care.

Among the many benefits of a fully integrated electronic system are:

- Increased patient satisfaction due to the online features (especially viewing lab results and refilling prescriptions) as well as an After Visit Summary generated by the system to summarize what a physician has told a patient during a visit
- A decrease in the number of physician office visits and phone calls (due mainly to the ability to e-mail your doctor)
- A reduction in redundant testing and imaging, since tests are never lost once they are entered into the system
- Increased adherence to guidelines based on best practices
- Improved patient health outcomes

There is much more research to be done both in KP and outside health care systems to document the return on investment for health information systems and how to maximize the potential benefits. But with or without definitive cost-benefit data, information technology is here to stay and Kaiser Permanente is making a major strategic investment in this technology. It has started experimenting with e-care and telemedicine and expects to do much more of that in the future.

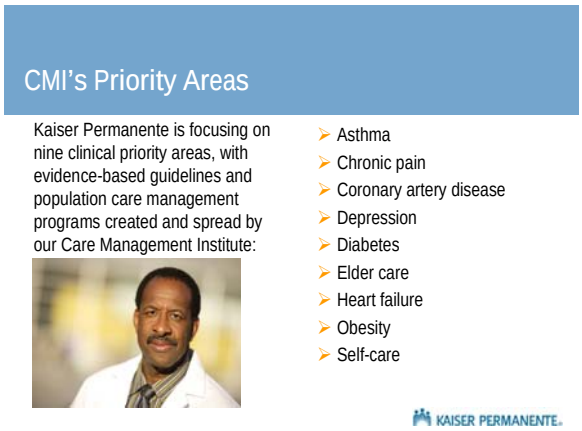
Care Management

Although KP has been involved for decades in predicting the needs of its members and developing treatment guidelines, these activities blossomed with the creation of The Permanente Federation of medical groups and – also in 1997 – the creation of KP's Care Management Institute (CMI). CMI's mission is to improve health outcomes through the identification, implementation, and evaluation of nationally

consistent, evidence-based, population-oriented, cost-effective health care programs. The philosophy that guides this work is: "making the right thing easier to do."

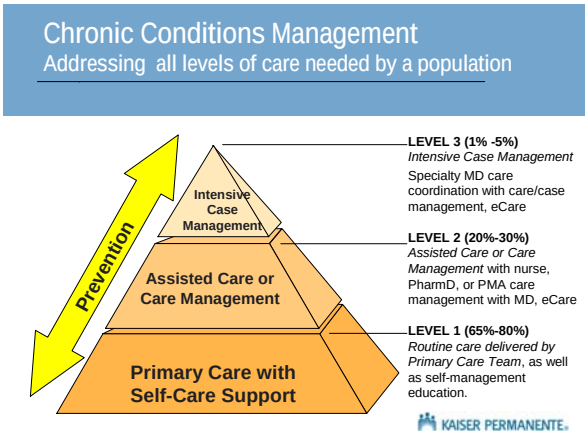
CMI produces the guidelines that feed into KP HealthConnect prompts and other material that physicians can access to help them in diagnosis and treatment. Other methods of dissemination of guidelines are also used. In KP-like consensus fashion, peer groups across regions feed into these guidelines as well as research and external sources.

Chronic care management is a key area of focus. California data has shown that 27% of members have one or more chronic condition and account for 64% of KP's costs. There are nine priority areas for which evidence-based guidelines and population care management programs have been created: 1) asthma (2.7% of members), 2) chronic pain (5%), 3) coronary artery disease (3.4%), 4) depression (7.1%), 5) diabetes (9.3%), 6) elder care needs, 7) heart failure (1.4%), 8) obesity (30% of adults), and 9) the promotion of self-care.



Since the late 1980s, KP has been investing in the infrastructure and programs for managing populations with chronic conditions, particularly those impacting Emergency Department and hospital utilization. In the last few years, it has completed implementation of these population management programs. Primary care physicians still manage their panels but with the support of proactive teams for chronically ill patients. Depending on the chronic problem, such teams may include nurses, medical assistants, health educators, pharmacists, social workers, psychologists, and specialists.

Members with chronic conditions are identified based on their history of doctor visits, prescriptions filled, lab test results, hospital admissions and emergency room care, and a registry database is maintained. As illustrated below, KP has defined three levels of intervention and case management: Level 3 is intensive case management" for 1%-5% of members; this is characterized by specialty care, case management, and electronic communications. Level 2 is "assisted care or care management" for 20%-30% with nurse, pharmacist, or physician's assistant care management in conjunction with the primary care physician, and electronic communications. Level 1 is defined as "primary care with self-care support" for the remaining 65%-80% of members.



At all levels one of the key challenges of managing patients with chronic conditions is helping them succeed and sustain behavior change through self-management and shared decision making (e.g., prescribing the right medicine does not mean they will take it, and a discussion about behavior change may not change behavior). Many publications and coaching techniques are used, and in some cases, small group workshops with 10-16 patients meeting to learn how to manage ongoing health conditions. Often their diseases are different in the same group but the issues – such as symptom management, ex-

ercise, nutrition, problem-solving, advanced directives – are the same.

KP is involved in an ongoing innovation project that is worthy of monitoring: "Primary Care Transformation: 21st Century Care Innovation Project." In partnership with the Institute for Healthcare Improvement (IHI), KP is engaged in pilots using its KP HealthConnect system, with three objectives: 1) Empowering members to be the "real" primary care provider with the care system providing people and tools to support the member; 2) Supporting panel ownership with earlier intervention in disease progression and greater oversight of members with chronic disease; and 3) Offering alternatives to face-to-face office visits, such as phone or e-mail visits, which can build capacity and give members choice. At pilot sites, clinical care teams unite with members and families in a "pact" to collaborate on plans and communication techniques that will help members improve their health.

According to the project coordinators, preliminary findings of the transformation project show significant improvements in preventive screening rates and resulting outcomes, decreased number of office visits due to phone and e-mail alternatives, and increased member and provider satisfaction.

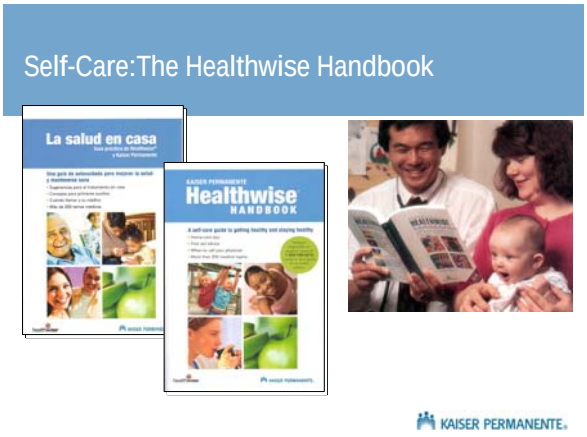
Self-Care and Health Promotion

It's estimated that about 80% of all medical symptoms are self-diagnosed and self-treated without professional care. Thus, patients are the true primary care providers and one important role of a health care organization is to teach their members how to take care of themselves.

If you review Kaiser Permanente's history, you find doctors giving noontime lectures to workers in the 1930s and 1940s to teach them how to stay healthy. With a prepaid program, there is an economic incentive to keep members healthy and to treat disease earlier rather than later when it may have become more complicated.

Today, Kaiser Permanente offers hundreds of health education classes at each of its medical centers, on topics ranging from stress management to diabetes care to quitting smoking. Health educators may be nurses, pharmacists, doctors, or professional teachers with master's degrees in public health.

In addition, Kaiser Permanente sends all of its members a copy of The Healthwise Handbook, either in Spanish or English. This guide to hundreds of medical conditions includes home care tips as well as advice about when to call your doctor or go to an emergency room. The same information and much more is also available on the Kaiser Permanente Website in both English and Spanish. Most of it can be viewed by the general public as well at kp.org.



In addition to this patient information, Kaiser Permanente physicians regularly encourage their patients to quit smoking or improve their lifestyle in other ways. They may "write a prescription" for a weight management or a menopause class rather than a medication.

Since 2004, Kaiser Permanente has had a health promotion campaign, called "Thrive" in English and "Viva Bien" in Spanish. The advertisements that are part of this campaign show people engaged in healthy activities. They also emphasize the importance of a good attitude to staying healthy. During the same few years that these ads have been running, Kaiser Permanente has been increasing its investment in health education for members and employees. It has also improved the food served to patients in its hospitals and has contracted with local farmers to offer farmer's markets with fresh fruit and vegeta-

bles once a week in front of most of its medical centers. Kaiser Permanente is clearly practicing what it preaches.

Kaiser Permanente's Thrive Campaign

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To summarize, a key to Kaiser Permanente's success is its integration. This involves:

- Integrated insurance and delivery of health care
- Integration of primary care doctors with specialists and other health care professionals
- Integrated facilities, where members can see a doctor, attend a health education class, fill a prescription, get tests or go to the hospital – all at one location
- Integrated decision-making, with input from physician leaders, hospital and health plan administrators, and labor leaders
- Integration of information technology with care management
- Integrated incentives – where employees and physicians share the same organizational incentives to keep members healthy.

Full text in Spanish at www.risai.org

Between 2004 and April 2008, Kaiser Permanente International offered a program called The Integrated Health Care Experience for international visitors interested in learning more about Kaiser Permanente. Hundreds of health care leaders from 30 countries attended this program. Starting in October 2008, this program is being renamed Integration and Innovation in Health Care. While the October 2008 program is full (it's limited to 50 participants), plans are underway for an April 19-22, 2009, program. For more information, e-mail molly.porter@kp.org or go to: http://www.kp.org/international

Also since 2004, the University of California at Berkeley has been offering the Global Health Leadership Forum (formerly called the Advanced Health Leadership Forum), with one week in California – including half a day at Kaiser Permanente – and six months later a week at a European site. For each of the key health policy and management issues (such as integration, incentives, financing, private-public mix), participants learn which approaches have been proven to work and current innovations – both from the expert speakers and the ensuing discussions. The program has attracted senior health executives from governments and organizations from over 36 countries. The next program takes place January 11-17, 2009, and registration is now open. For more information, e-mail ghlf@berkeley.edu or go to: http://ahlf.berkeley.edu.