



Statement of

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on behalf of the

Kaiser Permanente Medical Care Program

at the request of

Senator Ron Wyden (D-Ore.)

Delivery System Reform – The Need for Transparency, Payment Reform, and

Improved Care Coordination

Senate Finance Committee Health Summit

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Senator Wyden, thank you for the invitation to be here today. I am Jack Cochran, the Executive Director of The Permanente Federation, the national umbrella organization for the regional Permanente Medical Groups, which comprise the physician component of Kaiser Permanente. The Permanente Medical Groups employ more than 14,000 physicians, who care for approximately 8.7 million Kaiser Permanente members. I appear today on behalf of the national Kaiser Permanente Medical Care Program.

The Delivery System Matters

Few informed observers would disagree that the U.S. health care system is experiencing a profound crisis, as evidenced by skyrocketing costs; inconsistent, suboptimal care; and decreasing access to care.¹ More than 47 million Americans – or 16 percent of the population — are without health insurance.² We spend significantly more on health care per capita than other industrialized countries, yet RAND researcher Elizabeth McGlynn’s widely publicized study reminds us that adults in the United States receive only about 55 percent of recommended care.³

We applaud the Senate for addressing health care reform. We encourage you to put this issue at the top of your agenda. Patients are not waiting for the perfect insurance product. They want affordable, safe, high-quality care now. However, health reform is not just about expanding access, although access is certainly critical. Equally important are the

¹ F.J. Crosson, “The Delivery System Matters,” *Health Affairs*, November/December 2005; Vol. 24, No. 6: 1543-1548.

² U.S. Census Bureau. 2008.

³ E.A. McGlynn, et al., “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine*. 2003; Vol. 348: 2635–2645.

issues of quality and efficiency of the health care delivery system. As a nation, we could be doing so much better.

In its landmark *Crossing the Quality Chasm* Report, the Institute of Medicine (IOM) told us that “the current care systems cannot do the job. Trying harder will not work. Changing systems of care will.”⁴ The IOM report envisions a delivery system capable of meeting six challenges:

- Evidence-based care processes
- Effective uses of information technology
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services, and settings over time
- Use of performance and outcomes measurement for continuous quality improvement and accountability

A Better Future State

We believe that a better future state in health care must meet these challenges.

Fortunately, a model already exists for doing so – the integrated delivery system.

Examples include Intermountain Healthcare, Geisinger Health System, Henry Ford Health System, Group Health Cooperative of Puget Sound, Mayo Clinic, the

⁴ Institute of Medicine, Committee on Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington (DC): National Academy Press; 2001.

Veterans Administration, and Kaiser Permanente. Evidence increasingly shows that improved “systemness” drives quality and efficiency.

In a recent literature review, leaders of high-performing integrated delivery systems suggest several characteristics that are key to their performance:⁵

- *Organizational Culture.* Shared vision, values, and sense of mission around stewardship for both individual patients and populations is critical to performance.
- *Clear, Shared Aims.* Clarity of aims allows for meaningful performance measurement and encourages internal, transparent sharing of performance data. Shared aims also ensure that different parts of the organization are not hampering one another’s attempts to improve quality and efficiency.
- *Strong Physician Leadership.* Many of the best-known integrated delivery systems and large multi-specialty medical groups were founded by strong and charismatic physician leaders.
- *Purposeful, Collective Governance.* Someone or something (e.g., a board of directors) can cause the organization to act collectively and intentionally to improve quality or efficiency.
- *Accountability and Transparency.* Accountability to employers and patients, coupled with transparency of information, can improve quality of care. Research

⁵ L. Tollen, “Physician Organization in Relation to Quality and Efficiency of Care: A Synthesis of Recent Literature,” The Commonwealth Fund, April 2008.

shows that groups with external incentives – financial or otherwise – for improving quality tend to score better on quality indices.

- *Workforce Planning and Sophisticated Selection Processes.* In organized delivery systems, leaders can select providers for participation, excluding those who do not meet standards.

The traditional fee-for-service (FFS) system discourages the organized, integrated care that is the hallmark of systems. Under FFS, physicians and hospitals are rewarded for taking actions – doing procedures, prescribing drugs, performing tests, etc. – regardless of whether the best evidence calls for such action. FFS may also stand in the way of cooperation and collaboration across the delivery system, as each provider has an economic interest in providing more services for the patient rather than coordinating with other providers to determine how much and what mix of care is ideal.

**COMPARISON OF FEE-FOR-SERVICE AND PREPAID GROUP PRACTICE
OR ORGANIZED DELIVERY SYSTEM APPROACHES**

Health Care System: Ideal Elements	Fee-for-Service, Indemnity, or Autonomous Units	Prepaid Group Practice or Organized Delivery System
Focuses on meeting the population's health needs	Focuses on individual sick patients	Focuses on enrolled populations
Matches service capacity to the population's needs	Occurs by chance only	Potential for coordination and economies of scale and scope
Coordinates and integrates care across the continuum	Difficult to accomplish	Ownership and alliances provide potential for integrated care
Has information systems to link patients, providers, and payers across the continuum of care	Has neither the resources nor the elements of the system in place	Has elements in place for linkage to occur
Is able to provide information on cost, quality outcomes, and patient satisfaction to multiple stakeholders: patients, staff, payers and purchasers, community groups, and external review bodies	Insufficient volume per provider to trust the data, even if it could be produced	Infrastructure exists to provide reliable data over time
Uses financial incentives and organizational structure to align governance, management, physicians, and other caregivers in support of achieving shared objectives	Has little capacity to do this	Potential exists; some evidence that it occurs
Is able to improve continuously the care that it provides	Depends on individual motivation and skill	Potential exists given the existence of infrastructure to do it
Is willing and able to work with others to ensure that the community's health objectives are met	Highly variable, dependent on individual interest	Broad-based potential exists due to population focus

Source: S. Shortell and J. Schmittdiel, "Prepaid Groups and Organized Delivery Systems: Promise, Performance, and Potential," Chapter 1. *Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice*. Alain C. Enthoven and Laura A. Tollen, Editors, San Francisco: Jossey-Bass, 2004.

While the traditional fee-for-service system emphasizes physicians as decision makers, integrated delivery systems rely on teams (often led by physicians, but including nurses, pharmacists, and other health care and administrative professionals) to work together with patients to provide care. Evidence tells us that a highly functional health care team provides a superior care experience for patients and increases the morale and satisfaction of physicians, nurses, and other health care professionals. Research on patient care teams suggests that teams with greater cohesiveness are associated with better clinical outcome measures and higher patient satisfaction.⁶

Kaiser Permanente

Kaiser Permanente's founding principles of partnership, integration, and prevention have withstood the test of time throughout our more than 60-year history. We are the nation's largest integrated health care delivery system, providing comprehensive health care to nearly nine million individuals in nine states (California, Oregon, Colorado, Georgia, Hawaii, Maryland, Ohio, Virginia, Washington) and the District of Columbia.

We have found strength and opportunity through the fundamental and often unique partnerships within our organization: the physician and patient relationship; the collaboration between labor and management; the linkage of clinical research to improved care delivery; our investments and involvement in the communities we serve;

⁶ K. Grumbach and T. Bodenheimer, "Can Health Care Teams Improve Primary Care Practice?" JAMA, March 10, 2004; Vol 291, No. 10, 1246-1251.

and the shared coordination of care across inpatient, outpatient, ancillary services, and all the settings of care delivery.

In 2003, Kaiser Permanente began the KP HealthConnect™ project, the world's largest civilian deployment of an electronic health record. KP HealthConnect™ is a comprehensive health information system that includes one of the most advanced electronic health records available. It securely connects 8.7 million people to their health care teams, their personal health information, and the latest medical knowledge, leveraging the integrated approaches to health care available at Kaiser Permanente.

In April of this year, we completed implementation in every one of our 421 medical office buildings, ensuring that our 14,000 physicians and all other ambulatory caregivers have full access to members' clinical information. In addition, we have completed the deployment of inpatient billing; admission, discharge, and transfer; and scheduling and pharmacy applications in each of our 32 hospitals. Now, we are in the midst of an aggressive deployment schedule of bedside documentation and computerized physician order entry (CPOE). As of today, we have 15 of our 32 hospitals fully deployed and will have 25 completed by the end of the year.

One of our greatest lessons has been how much KP members value the ability to use online tools to manage their health. Launched in 2005, our personal health record, **My Health Manager**, now has more than 2 million active users. This represents the largest user base of online personal health records in the United States. Using direct links to actual clinical and operational systems, we are able to provide our members with access

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to robust features, including access to lab test results, appointment scheduling, prescription refills, and even the ability to securely email their doctors.

To date, our members have viewed over 56 million lab test results online, sent over five million secure email messages, made over two million online visits to book and review future appointments, and logged over one million online visits to view past office visit information.

At Kaiser Permanente, we are already realizing the value of health IT. With 24/7 access to comprehensive health information, our care teams are able to coordinate care at every point of service – physician’s office, laboratory, pharmacy, hospital, on the phone, and even online. Our early results demonstrate that health IT, as *Crossing the Quality Chasm* predicted, helps to make health care safe, effective, patient-centered, timely, efficient, and equitable.

Kaiser Permanente has made a huge investment in IT, both financially and philosophically. We believe it has the power to transform the way we deliver health care and improve patient health. Since the deployment of our integrated medical record, we have begun to see major advances in the ability to use information systems as a diagnostic tool (for identifying and understanding patients with certain risk factors) as well as for appropriate therapeutic intervention (for encouraging adherence and therapeutic intensification or moderation when needed).

For example, our use of IT and our comprehensive approach (partnership of primary care providers, specialists, nurses, and pharmacists with accountability across the continuum

of care – preventive, chronic, and acute) have significantly reduced emergency department visits and mortality. In Kaiser Permanente Colorado, we’ve seen a 60 percent reduction in cardiac mortality over time, measured against historical data. Based on NCQA data as compared to the national HMO average, we prevent more than 280 cardiac events annually in Colorado and realize \$2 million in hospital savings. In Northern California, you would have a 30 percent lower chance of dying of heart failure if you are a member of Kaiser Permanente versus the general regional population. In Oregon and Washington, the use of KP HealthConnect™ in a new Regional Telephonic Medicine Center staffed with emergency room physicians and advice nurses has resulted in an 11 percent reduction in the number of members who need to visit the emergency room between the hours of 12 noon and 10 p.m. From 2004 to 2007, combining the power of our IT systems and our integrated delivery model, we have been able to increase mammography screening rates in Southern California for female members aged 50-69 from 80 percent to nearly 90 percent.

Road Map to the Future

Congress has the ability to create an environment that promotes more organized delivery systems. First, payments should reward higher quality, not higher quantity. Mechanisms designed to do this include prepayment, coupled with quality measurement and reporting, and value-based purchasing, which can build upon the fee-for-service system. Care coordination should be encouraged and rewarded. Current pilot projects being

implemented around the medical home model hold promise for promoting primary care and improving care coordination.

Second, the unit of payment should be large enough to encourage providers to seek efficient combinations of resources. A bundled payment for a complete episode of care, for example, might encourage coordination of inpatient and post-acute care.

In addition, Congress should encourage the development and adoption of common standards for health information technology. We believe all consumers should be able to rely on an appropriate and consistent minimum level of privacy and security protection when it comes to their personal health information. Congress should promote preventive care and the management of chronic conditions. Finally, we strongly support more investment in comparative effectiveness research.

At this time in history, our nation is facing a critical confluence of factors:

- Affordability
- Inconsistent, suboptimal care
- Nursing and other health care worker shortages
- Supply and sustainability of primary care physicians
- Need for essential major investments in technology and systems (including electronic health records)
- Growing demand for health services as baby boomers enter Medicare

At Kaiser Permanente, we believe the keys to the solution will be health care led by clinicians, integrated with functional health IT systems, and staffed with innovative, enthusiastic, computer-enabled health care professionals.

We have an ethical responsibility to keep health care affordable, because high clinical quality without affordable access isn't.

We look forward to working with you to achieve these goals.
