

Permanente Medicine in a Changing World: Challenges and Opportunities

By Jed Weissberg, MD

The practice of evidence-based medicine (EBM) is central to the philosophy of the Permanente Medical Groups (PMG), but our beliefs don't stop the world from changing around us. Physicians practicing EBM within the PMG will face a number of changes in the coming years—both positive and negative.

Among the positive changes, the most obvious and perhaps the most significant is the implementation of KP HealthConnect. Kaiser Permanente's (KP) Care Management Institute recently identified five factors that enabled KP facilities to achieve program-leading performance in diabetes care:¹

- Financial incentives
- Action plans (patient-specific and personal)
- Automated medical record
- Outreach and follow-up
- Provider alerts and reminders.

Implementation of KP HealthConnect will significantly boost four of the five key success factors for effective diabetes care—all but financial incentives.

In addition, a growing number of interregional networks are disseminating EBM throughout KP, including the Guidelines Directors' group for issues such as colorectal and cervical cancer screening; the Inter-Regional Breast Care Leaders; the Inter-Regional New Technologies Committee; and many others.

Another encouraging development is that KP is not alone in seeking to demonstrate the value of multispecialty group practice. The Council of Accountable Physician Practices—an alliance of 28 prominent group practices, including the eight Permanente Medical Groups, the Mayo Clinic, and the Cleveland Clinic—has found that EBM is a key success factor in roughly 80% of all quality improvement projects among its member organizations.²

Unfortunately, our ability to practice EBM faces a number of challenges. For example, Americans on average are treated with recommended medical care processes only about 50% of the time.³ Many Permanente physicians probably believe that they outperform the

national average in applying EBM, but the comparable percentage for KP patients is still unknown. The most common obstacles to use of recommended care processes⁴ probably also occur within Permanente Medicine to a degree.

Lingering disparities of care present another challenge. Many Permanente physicians intuitively believe that disparities of care don't exist in their own practices, but usually lack hard data to validate their belief. However, limited data suggest that KP may perform better than other organizations in applying EBM to a culturally diverse population and narrowing disparities of care.^{5,6}

A number of studies have also found that even though EBM should apply globally, much of the care that patients actually receive is driven by regional and local variations in practice.^{7,8} Data on practice variation within the PMG is limited, but we do know that significant practice variation exists for procedures such as angioplasty.⁹

In the meantime, marketplace factors are changing the financial relationship between KP and its members and possibly driving changes in the ability of Permanente physicians to practice EBM. In response to heightened competition related to insurance product offerings, KP is implementing new insurance products that shift more of the total cost of health care from employer groups to members. Rising out-of-pocket expenses may create incentives for members to delay office visits and thereby reduce opportunities for preventive screening.

We still don't know whether purchasers will be willing to pay more for EBM, even if it results in demonstrated quality improvement, or whether EBM actually saves money.^{10,11} Most employer-group purchasers of health care are focused on cost not quality—in deciding which plans they should offer to their employees. This preoccupation with costs will probably continue as long as annual increases in health care expenditures remain in the double digits.

The net outcome of all of these factors on our ability

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to practice EBM is still unknown, but the physician leadership of the PMG and the Permanente Federation remain committed to finding better ways to help front-line physicians practice medicine according to the latest in scientific knowledge. ❖

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Glossary of Evidenced-Based Medicine Terms

Absolute Risk Reduction: The difference in the event rate between the control group and the treated group.

Algorithm (Clinical): An explicit description of steps to be taken in patient care in specified circumstances.

Balance Sheet: A compact display of quantitative estimates of the effects of alternative treatments on all the important outcomes, so that physicians, patients, and other decision makers can more easily grasp the consequences of the different options they face.

Care Management (or disease management): Coordinated health care, for logical groupings of members, intended to prospectively improve, maintain, or limit the degradation of their functional status.

Clinical Practice Guideline: A systematically developed statement designed to assist practitioner and patient in making decisions about appropriate health care for specific clinical circumstances.

Cost-Benefit Analysis: Converts effects into the same monetary terms as the costs and compares them.

Cost-Effective Analysis: Converts effects into

health terms and describes the costs for some additional health gain (eg, cost per additional myocardial infarction prevented).

Evidence Tables: Organizes and summarizes evidence from the medical literature. They are used in documenting evidence in guidelines and facilitating discussion. They may also be used as decision support in clinical practice guidelines.

Meta-Analysis: An overview that uses quantitative methods to summarize results.

Number Needed to Treat (NNT): The number of patients who need to be treated to prevent one bad outcome.

Population: In research, the group of people being studied, which may or may not be the population of a particular geographical area.

Randomized Controlled Clinical Trial: When a group of patients is randomized into an experimental group and a control group. These groups are followed up for the variables/outcomes of interest.

Registry: A means of storing and tracking information on a common set of patients, eg, members with asthma.

Shared Decision Making: When patients participate in making medical decisions about their care.

The glossary of terms was developed using the following sources:

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