By David M. Lawrence, MD

Lost Signals

***I** am honored to provide this essay for the inaugural issue of* **The Permanente Journal.** *The new journal will help us inform one another and others who read it about the special ways we care for our members. Setting clinical standards in American medicine through innovation and population-based research has been a significant contribution of Kaiser Permanente throughout our history. This journal and those who contribute to it continue a legacy of which we can all be proud. Congratulations to the Permanente Medical Groups.*

Most of us have had the experience of driving under high-voltage power lines and losing a radio signal to deafening static. Or having a favorite station drowned out by an unwelcome one. Or watching an indistinct image fade in and out on a blurry, snow-filled TV screen. Sometimes the interference is so powerful, it can overwhelm any signal no matter how strong. Sometimes an unwanted signal is simply clearer, more powerful, and closer to the listener. And sometimes the original signal is too weak, too indistinct to be transmitted very far, so that other signals, only slightly stronger, can replace it.

Our situation in Kaiser Permanente is like this. We face extraordinary challenges in telling our story effectively to the public and to our membership at a difficult, confusing time in the history of health care in the United States. We'd like to tell about the high quality of care we provide every day, about our standard-setting work in developing evidence-based guidelines for certain clinical conditions, about our commitment to use our "profits" to improve the health of our communities rather than to enrich investors. But our story keeps getting lost in static and interference.

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Last year our OB/GYN leaders in Northern California reviewed the evidence from the world scientific literature, coupled it with their own experience and data, and concluded that there was a better way to provide prenatal care. The innovation: to reduce visit frequency and strengthen the content of each visit. It was good for mothers and babies, and good for us. The reaction to our announcement was instantaneous and negative. Consumers, consumer activist groups, and the press accused us of cutting back on needed care to save money and "feed our bottom line."

Our HEDIS results, our unique success with NCQA accreditation, and our commendations by JCAHO for our hospitals are reasons to be proud. From well-designed clinical outcome studies to ratings in popular magazines, we are ranked at the top or among the top-performing health care systems in the country. Yet we are criticized in the press for compromising quality and sacrificing appropriate care for profit. Consumers are unimpressed by objective data and continue to make their decisions about which health care organization to join based on subjective, and to us, superficial criteria.

We have excellent nurse advice systems, urgent care availability, and emergency care capabilities. We have a unique balance of primary and specialty care specialists and services. We have no financial motive to restrict or discourage care. In fact, most of us in Kaiser Permanente would agree that the better the care, the less expensive it is for us and for our patients. But we are criticized by consumer advocates, our motives are questioned by authors like George Anders,[1] and we are pursued by plaintiffs' lawyers for allegedly withholding needed care because of our drive to maximize profits or compete on cost.

But the problems can't all be laid at the feet of the press, or the consumer advocates, or disgruntled physicians and health care workers. When we talk to members who are positive and satisfied with Kaiser Permanente; when we talk to consumers who have left us voluntarily for other plans; when we talk to people who wouldn't consider joining us; when we survey our members about our organization, the story is remarkably consistent. Our services aren't good enough. We aren't yet meeting the expectations our members have for convenience, simplicity, reliability, and caring. This isn't true for everybody. It isn't true for every part of our organization. But often enough to be a problem, this is the story people tell about us.

The primary reason members give for leaving us voluntarily is dissatisfaction with our service; in particular, the quality of caring and attention given them by the system, the doctors, and the staff. The principal reason people won't join us is because of the poor service they associate with us and their perception that bad service means bad care. Even a disheartening number of people who stay with us talk about "having to learn to work our system." They often say things like, "I'd leave tomorrow if it weren't for the care my kids get. My kids can get in, but I have to fight to get an appointment, and when I do, they make me feel like they're doing me a favor." The main reason people question the quality of our doctors is that our services don't work very well for them. How can people trust our care when they don't believe we care enough to serve them well?

This, I believe, explains a good part of the stubborn gap in satisfaction between our members and the members of other plans. Close to 63% of our members versus 80% of our competitor plan's members rate themselves as very or extremely satisfied with their care experience.[2] This difference has persisted for years in spite of our efforts to introduce open access and to redesign services. While our performance has improved, and improved considerably, our competitors haven't stood still. As a consequence, we haven't made up much ground yet.

1 George Anders, a health writer for *The Wall Street Journal,* recently authored a book entitled, "Health Against Wealth." The first chapter was devoted to the celebrated *Adams* case in our Georgia Region.

2 The care experience refers to five major contributors to overall satisfaction and the decision to re-enroll with us: telephone access, access to appointments, having a regular physician, ability to see a regular physician, and attitude and attention of the physician.

DAVID M. LAWRENCE, MD is Chairman and Chief Executive Officer of Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals.

We can't lose sight of the larger context within which we are trying to establish a distinctive voice for Kaiser Permanente and raise the satisfaction of our members. Employees trust in their employers has been declining for over a decade, even accelerating in the past five years with the increasing pace of layoffs and downsizing. Employers have pushed managed care, arguing that unfettered fee for service medicine is too expensive. Imagine if you're an employee. What are you going to think when your employer arranges for you to choose among competing managed care options? "This is a take-away, one more example of an employer who cares only about costs. It can't be as good as what I used to have because I can't go where I want, and besides, I can't get care as easily as I used to when I need it."

Add to this the fact that American consumers have been socialized for at least half a century to believe that more care is better care, and the higher-tech, the better. As the futurist Ian Morrison likes to point out (he was born in Scotland, raised in Canada, and now resides in the U.S.), the Scots consider death to be imminent; the Canadians view death as inevitable; the Americans believe death is optional.

Small wonder, then, that consumers view what we consider as "appropriate care" to be "less care," and less care, of course, means lower-quality care. So when our members, bearing these biases, encounter our care and our services, there is real potential for losing the quality-of-care signal we want them to hear in the noise and interference of conflicting messages.

What's going on here? I think there are three factors at play. All of us know about the outside interference. Competition for the ear of the health care consumer is fierce. An endless stream of stories about managed care, HMOs, and Kaiser Permanente are sponsored by worried consumers, consumer advocates, disgruntled physicians and health care workers, concerned legislators, and a receptive press, each bringing a distinctive point of view to the field.

But we bear a large part of the responsibility, too. Our Kaiser Permanente quality signal is not as clear and unambiguous as it needs to be. The excellence of our care in one part of our organization is compromised by poor care somewhere else, making it hard to create a sharp, distinct, consistent image for the public. Without that strength at the core of our organization, without that consistently high standard of performance, our signal isn't strong enough to override the competing signals.

We confuse our message further with inconsistent, impersonal, and member-unfriendly services. Because service and caring is the language many consumers and members use to assess quality, our quality story gets written in a language in which we are only moderately fluent.

How do we break this cycle? How do we replace uncertainty and skepticism with trust? How do we strengthen our signal? We're doing several important things this year.

To address the problem of distinguishing Kaiser Permanente from others who call themselves managed care or HMOs, we will soon launch a major national effort focused on a clear message to our membership and to the nation. At the heart of this campaign is our story of quality and care, told better and more effectively than ever before. To do this well will require that we make critical decisions about which consumers we choose to serve, what their needs and expectations are, and how we are going to improve our services to ensure that we address those expectations in a way that binds members to us. Our public story has to be consistent with the reality of our members' experiences. In particular, it has to be aimed at those of highest risk of leaving Kaiser Permanente, the 37% of our members who remain neutral or dissatisfied with their care experience with us despite our best efforts.

We are also working with consumer advocacy groups to develop service and consumer protection standards for managed care organizations. These will create a formal understanding of what consumers can expect from us in quality assurance systems, service availability and ease of use, and grievance and conflict resolution proceedings. We have already joined with the American College of Emergency Physicians to develop legislation that would broaden the rights of consumers to decide when they need emergency care—the so-called "prudent layperson" rule.

To address our service gaps, we have initiated several efforts. First, we've asked all Health Plan/Hospitals leaders and invited the Medical Group leaders to partner with us to reduce voluntary turnover of our existing members in the next three years and dramatically improve the care experience our members have with us. We've established targets—more as aspirations than anything else—and built them into the incentives for Health Plan/Hospitals executives. We'd like to reduce voluntary turnover across the Program from three percent to two percent by the end of the year 2000. And we'd like to improve satisfaction with the care experience from 63% to 80% very or extremely satisfied in the same time frame to match the satisfaction levels of our competitors. We will make a number of investments, support innovations, and look for best practices to share across the Program in pursuit of this goal.

We have also moved primary accountability for attracting and retaining members to the local levels of

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our organization, where the needs and expectations of our members can best be understood and responded to most rapidly and directly. Profit and loss will be tracked locally, as will price, to encourage caregivers and managers alike to respond with sensitivity and creativity to their unique competitive conditions. We can and will take advantage of our national scope to leverage knowledge and skills. But the best solutions to our service challenges will be found locally, not nationally or even regionally.

And finally, with the PMG leaders, we have agreed to launch a major research and development effort to identify more effective ways to care for our members and to more appropriately organize and deliver the services our members want. These will be targeted at longer-term, larger-scale changes, while the day-to-day innovations occurring at the local levels will be the primary engine of change.

Our task is clear. We must reduce static and eliminate interference before our members and the public can see how good we are at taking care of people. To do this requires three things of us: first and foremost, we must be uncompromising about the quality of care we provide. It's up to every physician in the organization to ensure that he or she takes part in the dialogue to set quality standards, to assess the impact of clinical and organizational decisions, and to participate in the choices about clinical care options. Our quality must be uniformly superior throughout Kaiser Permanente. Any physician, any caregiver, any part of Kaiser Permanente bearing our name must be held to the same standards, so that superior care in one part of the organization isn't compromised by poor care in another.

Second, we must effectively tell our story ... creating an unambiguous national signal that distinguishes Kaiser Permanente from the others in health care. Whether working with consumers and consumer advocates, dealing with the legislature, developing relationships with the press, our story must be consistent, simple, and powerful, and told over and over and over again.

Finally, we must eliminate conflicting messages. We cannot ever again allow our services to be inadequate. We must organize all services for the benefit of our members, showing by our actions that we are here for them ... not for the bottom line, not to create wealth, not for our convenience.

The Kaiser Permanente story is a powerful one. We want our members and the public to understand us: our mission, our commitment, and our quality. It's up to us to create the strong, clear, unambiguous signal that will enable them to do so. ❖

"No problem can be solved from the same consciousness that created it."
Albert Einstein