

## Editors' Comments



Tom Janisse, MD, Editor-in-Chief  
**Primary Care Innovation**

Innovation will characterize and shape our future as Kaiser Permanente (KP). With the increased focus on the delivery of primary care services, how to innovate draws our attention. What form will innovations take? I believe that the most dramatic and important changes in primary care will be in "process" rather than "product." Unfortunately, little research exists on the processes of medical and health care service delivery. For example, in an upcoming issue we will explore the use of electronic mail interactions between patients and their doctors and health care team. Does age affect people's use of this communication mode? Do people continue to use this mode after initial orientation? Does this form of communication result in higher satisfaction and improved quality of care? While electronic mail uses information technology (a product), this advance is more a process innovation in communication. The "Cooperative Health Care Clinic" (group clinic) concept, originating with Dr. John Scott in Colorado and now in widespread use in many Regions, is an exemplary primary care process innovation. Developed to care for the elderly, the group clinic has resulted in increased quality of care and increased satisfaction for both patients and clinicians.

### Primary Care Research

How can we encourage and carry out research in both clinical and in health systems in primary care? As Dr. Mary Durham, Director of Center for Health Research (CHR) in KP Northwest said, "A tremendous amount of research needs to be done in primary care. We need basic information about the common problems in primary care and the way that care is delivered. Improvements are needed to identify, screen, and treat these conditions."

What are the common problems in primary care? Low back pain, headache, depression, and chronic conditions such as asthma, arthritis, and diabetes lead the list. Identification and research though is not enough. Once we innovate products and process, we must ensure the diffusion of those innovations into and across our integrated Program. Implementation has been the bane of innovation. Fortunately, Dr. Peter Juhn and the Care Management Institute of The Permanente Federation have focused talented people and concentrated resources on successful diffusion of innovation through attention to implementation processes.

### Learning Through Experience

During and after training, primary care physicians have accorded more value to learning through ex-

perience, both personal and from mentors. This practice experience, if gathered and compared to existing literature, would support construction of practical pathways for care—in effect the guideline development process. To complement this research work, additional value can be gained by helping primary care physicians understand the structure for creating designed controlled research for the commonly seen conditions in the medical office. Then featuring primary care research in publications would validate their contribution of practice experience. *The Permanente Journal* exists as a forum for this research, compounding this value by disseminating the discoveries and discussions across the Permanente Medical Groups.

### Primary Care Prevention

In the area of primary care prevention, we have primitive techniques for encouraging behavior change in our members. A course titled, "Motivational Interviewing," introduced into the 1997 Inter-regional Primary Care Conference addresses this. Denise Ernst from the CHR and Dr. Sam Weir from North Carolina PMG teach assessment of "readiness" in patients for change, and the appropriate questions and statements that motivate patients to move forward on the continuum of changing one's behavior—a complex human process. An example that may resonate with you is the featured quote in a brochure on smoking cessation which says, "Getting ready to get ready to quit smoking."

Behavior change in patients necessitates a change in physician behavior, since the physician is the change agent. This behavior change may require physicians to explore unfamiliar areas of knowledge, educational processes—like role playing—or new attitudes. Consider my poetic characterization of the evolution of the doctor-patient relationship.

### Evolution of the Doctor-Patient Relationship

|         |   |         |
|---------|---|---------|
| Doctor  | - | patient |
| Doctor  | - | Patient |
| Patient | - | Doctor  |
| Patient | - | doctor  |
| Person  | - | doctor  |
| Person  | - | Person  |

This embodies the concepts and processes of regard, acknowledgment, customer service, ego, partnership, negotiation, holism, and physician wellness.

*"A tremendous amount of research needs to be done in primary care. We need basic information about the common problems in primary care and the way that care is delivered. Improvements are needed to identify, screen, and treat these conditions."*

*— Dr. Mary Durham, Director of the Center for Health Research; KP Northwest*



### Alternative Medicine Process

In Washington State, attention to alternative and complementary therapies has been legislatively and legally imposed. In June, the 9<sup>th</sup> Circuit Court of Appeals confirmed the interpretation of the Washington State Insurance Commissioner, Deborah Senn, in implementing the "any category of provider" law enacted by the Washington legislature in 1996. The 9<sup>th</sup> Circuit Court overturned a lower Court decision which voided the law because of a suit brought by Washington and Oregon health plans—including Kaiser Permanente and then Group Health Cooperative of Puget Sound. These health plans (HMOs, HCSCs and indemnity carriers) questioned whether this new law is preempted by ERISA (Employee Retirement Insurance Security Act), and thus void. It is anticipated that the Washington State Insurance Commissioner will rely on the 9<sup>th</sup> Circuit Court's opinion to enforce the broadest interpretation of the law to the end of essentially mandating group health care coverage in Washington for such therapies as acupuncture, naturopathy, and massage therapy. The result of this has been to propel us into the provision of alternative therapies if requested by our members. Several questions we need to answer immediately are process or delivery system questions in primary care: Do we internalize these services by hiring alternative providers, or do we contract with a network of alternative providers, or both? How do we incorporate these evaluations and therapies into our integrated delivery system and electronic medical record? How do we credential alternative practitioners? How do we ensure the quality of that care, especially given our lack of understanding of alternative therapies, their potential complications, and potential complex interactions with our members' current medical treatments? Some of our members want these services and would expect that they are safe and efficacious. These are all process and systems questions.

### A Business Model for Medical Process Innovation

Since understanding practice processes will lead to innovation in primary care, a business model for "customization" aptly describes and elucidates the importance of process innovation in the four-phase cycle from "craft" to "customized" product or service (Figure 1).

The first step of customization (in our case, personalized care) is moving from **craft** (an individual's unique practice)—a dynamic process and product—to **mass production**—stabilizing the process and product. The second step is taking that standardized product or service through continuous **quality process improvement**—a dynamic process with a stable product. Once recognizing and defining a process improvement, the third step is **customization**—re-

turn to a stable process, although the product is now dynamic. The fourth step moves back to craft.

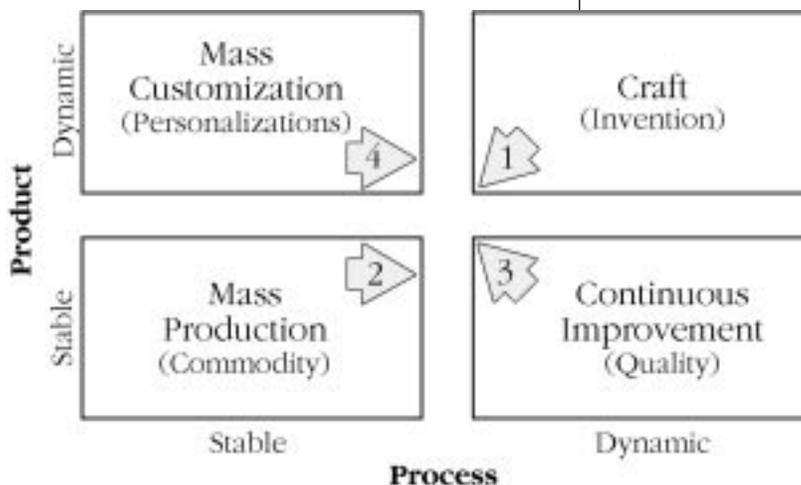
Let's use the group clinic as an example. The doctor-patient medical interview was a craft. As the interview process became more routine and predictable, it was standardized into a 20-minute doctor's office visit which could be scheduled three to an hour for an eight-hour day. However, this visit routine was too inflexible and ineffective for the care of geriatric diabetic patients with many other needs in an infrequent office visit. The process improvement step came in constructing a group clinic, combining several patients' single doctor office visits into a one longer multi-patient group clinic where those multiple needs could be met in one trip to the doctor. Variations of the group visit format and staffing required further process improvement until a well-functioning, highly efficient, yet flexible visit format was settled on—a customized service and personalized encounter included conversation and interaction with fellow patients, doctor, nurse, educator, pharmacist and nutritionist.

Research such as this in primary care processes will produce definitive value for our members and patients, and for clinicians and the health care team. One important component for primary care physicians is that process innovation requires active participation (or, at least, passive acceptance) of the importance of research to the life of the physician. Clinical and systems research requires this, since you cannot perform this work in a lab. However, the major benefits of participating will be process improvements of high value to clinicians because they will have optimal application in their local environments. ❖

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*"We need to think of an expanded array of services that we can call primary care and make them available to our varied populations of patients."*  
 – Scott Feurer, MD, Service Area Director; Northwest Permanente

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A.C. Boynton, "New Competitive Strategies: Challenges to Organizations and Information Technology." *IBM Systems Journal*/Volume 32, No. 1, 1993

Figure 1.

## Clinical Contributions

Arthur Klatsky, MD, Associate Editor



In this issue, we present articles about relatively uncommon problems in most practices as well as pieces about aspects of medicine which confront primary care practitioners on a daily basis. Permanente physicians, like all physicians, get excited and interested by the exotic, but need more constant update in "bread-and-butter" issues. We have a truly scholarly article by Edward Markell, MD, entitled "Amebiasis—or Disparosis?," which updates an aspect of an important enteric infectious problem. Few of us are able to keep up in the areas of parasitic and protozoan infestations, which we recall vaguely from memorization exercises in medical school days. It is with deep regret we report that Dr. Markell, a retired KP physician, died June 22 at the age of 80 shortly after submitting this article. Dr. Markell was world-renowned in the field of Tropical Medicine, and kept active in teaching and writing in this area. Few of us have patients who succeeded in losing more than 100 pounds; Drs. Vincent Felitti and Seleda Williams present a discussion of no less than 190 such patients in "Long-Term Follow-up and Analysis of More Than 100 Patients Who Each Lost More Than 100 Pounds." They properly emphasize the importance of maintenance of the weight reduction. The psychosocial predispositions to massive obesity and the aspects predictive of recidivism after substantial weight loss in this unusual group of patients make for fascinating and thought-provoking reading. On a related topic, but with far more day-to-day practice implications is Dr. Steven Masley's article, "Improving Dietary Compliance: How Can We Do A Better Job?" Dr. Masley's practical, sensible approach has great importance for most physicians, who tend—probably to an inappropriate extent—to relegate this very major area of disease management and prevention to other health practitioners. Finally, this issue includes another Perspective article from the July, 1944 *Permanente Foundation Medical Bulletin* entitled "Management of the Menopause" by Dr. David James. Dr. Reva Winkler, an Obstetrician-Gynecologist in the Southern California Permanente Medical Group, has written a commentary which includes a beautifully written and very practical update, with a delightfully personal flavor.

Once again, we earnestly invite comments from readers about any article or the Clinical Contributions section in general. Additions, corrections, disagreements, or personal observations are all pertinent. It would be very useful for the purposes of the *Journal* to have a vigorous correspondence section. ❖

## Health Systems Management

Lee Jacobs, MD, Associate Editor



The Health Systems Management section of this edition presents several topics that are a reflection of the changes that the Permanente Medical Groups are undergoing. First, Eric Shuman shares his experience as a long-standing Physician Assistant in primary care transitioning to an innovative role in providing consultative neurologic support. This topic is contrasted by this edition's Systems Challenge—the integration of behavioral health into Primary Care—in which specialty care is integrated into primary care. Several Permanente Medical Groups share their various pilot programs with the objective of providing support for the primary teams. Also included in this edition is an interview with Jill Steinbreugge, MD, the Federation's Associate Executive Director for Professional Development. Dr. Steinbreugge not only presents her strategy for developing and implementing physician development programs, but her comments also provide our readers with insight as to how the Federation intends to provide supportive initiatives to best meet the needs of our diverse Medical Groups. Finally, Bruce Perry, MD, presents an informative discussion on the evolution and the anticipated benefits of Permanente care management in this edition's "A Word from the Medical Directors."

Although I do believe that you will enjoy your reading, a true "conversation" can only take place if we hear from you. Your experiences, suggestions, and comments are welcomed! ❖

## External Affairs

Scott Rasgon, MD, Associate Editor



Our cover is of the breast cancer stamp made possible by the efforts of a partner in The Permanente Medical Group. His incredible story is in the External Affairs section and illustrates what he accomplished against all odds. This edition of the External Affairs section also has an article on Su Salud, which again reflects our commitment to community service and the people in our organization who make extraordinary contributions. On media matters, we reprint an editorial comment from *California Medicine* by Kate Christensen, MD, of The Permanente Medical Group. The Physician Speakers Bureau article is about a marketing advantage we enjoy because of the relationship between the Kaiser Foundation Health Plan and The Permanente Medical Group. There are great benefits of this relationship in our competitive health care market. Don Parsons, MD lets us know what is happening in Washington in his piece on the National Bipartisan Commission on Medicare Reform. ❖