commentary

KP's New Man at the Helm: George Halvorson

George Halvorson took over the helm of Kaiser Foundation Health Plan, Inc, and Kaiser Foundation Hospitals in May 2002, succeeding David Lawrence, MD, and becoming only the fifth Health Plan leader in Kaiser Permanente's 60-year history. As the former leader of Minnesota's HealthPartners organization—a nonprofit, integrated health care system with many similarities to Kaiser Permanente (KP)—Mr Halvorson came to KP with a reputation as an outspoken advocate for cost management through quality improvement and system integration, as well as for a more patient-centered health system. He has vigorously pursued both these themes in his first year at KP, where implementation of clinical information technology, "next-generation" insurance products, and a "same-day access" program have been among his top priorities.

In May 2003, Mr Halvorson's fourth book on health care, *Epidemic of Care,* coauthored with George Isham, MD, was published by Jossey-Bass.

The Permanente Journal allowed Mr Halvorson a few months to adjust to his new responsibilities before requesting an initial meeting. He promptly responded with a gracious offer to sit down and let the conversation take us where it would. The following are excerpts from that tape-recorded conversation.

—Tom Janisse, MD, and Jon Stewart, Editors

On the Impact of Cost-Sharing Insurance Products

TPJ: *It seems to many of us in health care that the dynamics of the insurance industry are undergoing a fundamental change from the old world of community rating to something new, and we still don't know what to call it or how to deal with it. All these so-called "skinny benefit" plans that appeal to young, healthy people are just a part of a really broad change. How will we either avoid getting swept along by competitive demands to do the same thing or, alternatively, adapt to these changes in a way that keeps us competitive and yet preserves what we call Permanente Medicine?*

Mr Halvorson: There are a number of things we need to do in response to that serious challenge to our future. It's critically important that we have a system where patients are tied to us for their long-term care and that the benefits we offer do not create a barrier to that care. We want patients coming in and getting the most appropriate care, and we want that care funded in appropriate and affordable ways.

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At the same time, we need to be flexible as we do so that we can allow for some cost sharing with patients who want to have a lower premium. Many of our buyers are demanding that we do exactly that. I think we can be flexible in benefits without having an adverse impact on the quality of care. The trick is to not have benefits that are so "skinny" that they create major financial barriers to care or change patient behavior inappropriately. I'm sure we do not want to go into a "catastrophic care" kind of insurance model. On the other hand, some levels of risk sharing can cause people to be more frugal but not to avoid necessary care. But other, greater levels of cost sharing could cause people not to bring their children in when they should. That wouldn't be good. The right answer is in the middle.

We now need to be eternally vigilant in understanding, employer group by employer group, exactly what the impacts are of the benefits being offered by our competitors in each group. There may be times when it would be better for us not to be offering our coverage and care in some settings. It can be financially damaging for us to stay in a group where there is obvious adverse selection, for example, staying in group "X" and getting only 5% of the group's members and

that 5% are the people who use 50% of the group's total care dollars. Look at the distribution of health care costs—I keep coming back to these figures: 1% of the population uses 30% of the care. Five percent of the population uses 50% of the care. Seventy-five percent of the population uses 15% of the care. And so if we lose the 75% (using the least care) and only maintain the 5% (using the most care), there's no possible way we can come out financially, no matter how wonderful we are at providing care.

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Eternal vigilance needs to be tattooed on the back of the hands of our sales force as we go out and look at how we're being offered in various settings. At the same time, we can do some cost sharing ourselves, and as long as it doesn't create a barrier to care, we can create some benefit designs that direct people into more tightly managed care. We have pilot studies going on right now in various sites where we do a risk-pool analysis and compare our risk with that of another carrier. We have pilot agreements in place where we adjust our compensation at the end of the year if we have a less-healthy population. We're also working at the design stage on other risk-sharing approaches that would deal very directly with the adverse selection issue. But part of the underpinning of that strategy is that the employers have to believe in our value and want to help us in a risk-sharing situation. They have to believe in their hearts and heads that we are delivering great value relative to our care. If they believe that we are the premier deliverer of care, then they're likely to be flexible in terms of a structure of reimbursement.

On Discussing Cost of Care with Patients

TPJ: *Permanente physicians have always practiced in the comprehensive benefit model of just taking care of patients. Whatever they felt was appropriate, they would order or do and assume that it was covered. With the rise in pharmaceutical costs, there's been the beginning of conversations with patients that physicians are not used to. That could become a significant part of the patient-physician interaction—"Which path should we take, given the deductibles you have or the kind of insurance you have." It seems to complicate the dialogue.*

Mr Halvorson: That's going to be particularly relevant in those areas where we have seniors without drug coverage. The seniors are the heaviest users of prescription drugs. If we get forced into a position of not having drugs as a covered benefit, then that new and potentially painful caregiver-patient dialogue will have to take place. We need to help our physicians understand how to manage that dialogue, because it's critically important to the seniors.

This issue is more problematic for prescription drugs than in other areas of care. For example, if someone has a $500 deductible, that's not going to keep him/her from going into the hospital if a physician says, "I need to put you in the hospital." It will be unpleasant to write the $500 check, but they're certainly not going to opt not to go to the hospital. I don't think that benefit approach is going to create a barrier to hospital care. These kinds of benefit packages do, however, ask patients to feel the pain of the price they pay with other health plans and with various insurance companies. And as we deliver a more efficient product, it will cause them to have more appreciation for what we're doing in that process. If we offer a deductible plan in competition with a Blue Cross or Aetna deductible plan, our inherent efficiencies should give us a price advantage that will make us more affordable and attractive to patients and consumers.

On Self-Care and Patient Empowerment

TPJ: *Could this discussion between doctors and patients about the cost of care actually be an opportunity to have a connection that is a window on a more important topic of self-care?*

Mr Halvorson: One of the side benefits of cost sharing could be to get consumers more involved in thinking about and talking about the treatment of their condition. We need to be prepared to take advantage of that opportunity and identify various ways patients can be involved in self-care, as well as some kinds of group care settings and various other settings that provide a higher level of efficiency and effectiveness.

I think we have the opportunity to create a truly informed patient and to create a dialogue with the patient that makes the patient a much more sophisticated self-caregiver. And if we do it in the context of an organized, integrated system where we're concerned about the patient's total health, I think that the potential for much better care is very high.

This is another area where the Internet can help. One of the things that we ought to be doing more is having the system reach out to patients with reminders about best self-care and appropriate care and having systems that at the time of care delivery prompt the

caregiver to remind the diabetic patient to do x, y, z in a systematic way. Basically, we should be able to offer individual customization of information in a very effective way at the time of care. There's a whole series of very positive and effective messages that we can convey when we reach out to the patient and say, "You're diabetic, and we're concerned. We'd like you to come in for a blood sugar or a mammogram. And, by the way, here are three things we'd like to remind you about." Patients in that communication environment feel cared for.

On the Quality Agenda

TPJ: *While the insurance industry is developing these insurance responses to the affordability problem, there seems to be a lack of attention to the quality agenda. Do you see an opportunity there for KP to again assert some leadership in terms of defining a quality approach to these same cost problems?*

Mr Halvorson: I think there's a huge opportunity there. I think there are two major forces going forward simultaneously in today's marketplace. One is the momentum of increased cost. That's creating a situation where employers are making decisions to avoid benefits, shift costs, etc. I've met recently with the leaders of more than a dozen Fortune 500 companies. Every single CEO in one-to-one conversation told me that his or her company is going to reduce benefits and increase consumer cost sharing. Everyone said that and most said it with some passion. That's one agenda—a lot of focus on direct cost. But the other major and important agenda is the quality agenda that Don Berwick at the Institute for Healthcare Improvement is part of and that the Institute of Medicine has been promoting through their patient safety and quality reports, such as *Crossing the Quality Chasm*.[1] People in Washington DC are finally looking at the Wennberg studies on practice variation. They have been around for a while, but they're finally beginning to have traction. It's a critical mass issue—an intellectual tipping point. When the American Diabetes Association says that two out of three physicians in this country are not delivering appropriate diabetic care and that diabetes is the number one single cost issue for Medicare—25% of all Medicare dollars go for the cure of diabetics—all of a sudden, many important policymakers are beginning to relate Point A to Point B on quality and cost and saying, "Wait a minute. Quality is part of the answer." There's a very useful momentum finally building on the quality side, and KP is better positioned than anyone in the country to seize that opportunity and show what can be done. Now is the time for us to come through and really deliver on the potential of this model, because the world is now ready to hear the message. I think the timing is working very much in our favor right now.

On Service and Access Improvement

TPJ: *Can you comment on the relationship, in your mind, between service and quality? Does the consumer's experience of service alter perception of quality? Is better service better quality?*

Mr Halvorson: There's no question that the perception of quality goes up significantly when service improves. When we moved to an aggressive improved-access program in Minnesota (at HealthPartners), and then went back after the fact and asked patients about their satisfaction levels, the number of people extremely satisfied doubled. The other thing that was fascinating was the significant improvement in the perception of quality when appointments were conveniently available. People felt that they weren't getting quality care if they couldn't get in quickly. The quality didn't actually change a bit. The underlying quality was exactly the same before and after we implemented advanced access. But for patients, just getting in and having a face-to-face encounter with their Primary Care Physicians represented a quality encounter.

The other thing that was fascinating was the significant improvement in the perception of quality when appointments were conveniently available.

One of the things I'm really happy about is the consistent commitment across KP to move to some form of advanced access model, because I know that when it's finally in place the physicians are happier; the nurses are happier; and the receptionists are much happier because they're not dealing with grumpy patients sitting in the waiting room. Patients love advanced access, because they feel cared for, and they feel like the organization is on their side. It's win-win-win.

Keep in mind that the patient most likely to leave us at open enrollment is the very healthy one who visits us, at most, once a year. This patient, in effect, pays us $2500 in an annual premium for that one visit. We need to give this patient a care experience that makes it worthwhile to pay us that $2500 again next year.

On Team Care

TPJ: *The care of patients with chronic disease requires the expertise of health professionals from many disciplines. Can this occur just through a well-coordinated referral system, or is there a necessity for a high-performing team?*

Mr Halvorson: One of the greatest advantages we have in our model is the potential to practice in a truly team-based environment. When teams are in place and functioning, the morale of the team members goes up, the satisfaction of the patient goes up, and the quality of the care goes up. Team care truly does work. In order to get there, we need to have a systematic approach to team implementation. Teams don't just happen, or most of them don't. We need to help create them. However, most practitioners haven't been trained to work in team-like settings. There's a learning curve. But team support is a teachable skill. And once in place, it's something that people want to self-perpetuate.

Of course, it goes without saying that everyone in the entire process, starting with the patient, wants the teams to be physician-led.

Patients also like team-based care. Patients have a strong sense of wanting to have a direct relationship at a human level with their caregiver, and that's generally perceived to be the physician. But if you've got a team environment that feels like a team, functions like a team, and acts like a team, you get almost the same reaction from the patient, that "I was seen by my team."

Of course, it goes without saying that everyone in the entire process, starting with the patient, wants the teams to be physician-led. The relationship the patients value most deeply is the relationship they have with their physician. They're very happy to extend that to their physician and his or her team, but there's still a need for the physician to be seen as the individual personification of the group, or even as the personification of the organization. That's another reason why something like the advanced access initiative is important—because patients are seeing more of their own physicians, not the next available physician.

Of course, there's a special skill involved in team leadership, and it usually has to be learned. The style that works best is a style of participative leadership. The team needs a leader, but the team also needs a process that allows all the team members to feel valued, heard, and appreciated. That's critically important. The leader has to appreciate that perspective and deal with it appropriately.

On the State of the KP Partnership

TPJ: *The relationship between the physicians and the Health Plan at Kaiser Permanente is somewhat different from the relationship you were accustomed to at HealthPartners, where you had a staff model at the core and a fairly large physician network. Could you comment on the status of the KP partnership today?*

Mr Halvorson: My sense is that our partnership process here is working exceptionally well. We're all talking through every issue, every agenda. We've spent a lot of time figuring out joint objectives and goals—we have a joint and mature vision for where the organization ought to go, and we have a sense of what roles we each need to play to get to that vision.

It's pretty remarkable and very productive. Dr Jay Crosson (Executive Director of the Permanente Federation) gave a talk recently to a medical society policy council. I would have been perfectly happy to take that talk word for word and give the same talk myself. I couldn't see anything that would have changed. I just gave a talk to a set of health care leaders in Los Angeles, and I used Dr Crosson's slides. I can't think of an area right now where we are not in sync. We want great care. We both want this program to be the model for America—for the world. In terms of the specifics of our current joint strategy, the commitment to an automated medical record is something that I believe in passionately, and I know that every single one of the medical directors is completely committed to that agenda. I think we are so well in sync partly because we talk so often and so much. I've been meeting with the medical directors at many of their board meetings, and it's an open agenda. Any issue that anybody wants to bring up is put on the table. Dr Crosson, in turn, comes to the KP Board meetings, and it's the same thing. That board is grateful to him for the superb contribution he makes. We have created a level of dialogue and communication that's pretty extensive, and I believe it's paying off in a comparable level of mutual trust targeted at a common vision of the future.

There's no reason for us not to be the best care system and health plan in the world. We have the resources, talent, expertise, patient base, commitment, vision, and strategy to get there. It will take hard work, but it definitely can be done.

This is a great place to be and a great time to be here. ❖

Reference

1. Institute of Medicine, Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington (DC): National Academy Press; 2001. Available on the World Wide Web (accessed June 4, 2002): www.nap.edu/catalog/10027.html.