



## Notes From the Permanente Executive Conference— Improving the Health Care Value Equation: Access, the Care Experience and Resource Management

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More than 125 Permanente physician-leaders, including virtually all the PMG Medical Directors and their executive staff, gathered in Scottsdale, Arizona, on November 2-3, 1999, for the interregional Permanente Executive Conference, sponsored by The Permanente Federation. Opening the conference, Federation Executive Director Jay Crosson, MD, warned that this year’s meeting, unlike the combination conference-social gatherings of years past, was designed to do work—and ten solid hours of intensive presentations, panel discussions, and table-based exercises, all on day one, proved his point. By the time the executive medical directors assembled on the conference room dais the following day to commit their respective regions to specific follow-up actions in the areas of access, the care experience, and resource management, a significant amount of work had been achieved.

What follows are notes on some of the highlights of an extremely content-rich conference.

### The Context for Improving the Value Equation: An Insider’s View

Having dedicated the meeting to the late Paul Lairson, MD, who played the critical pre-Federation role in first bringing the Permanente Medical Groups together to do common work, Dr Crosson set the stage for the meeting through a review of market trends over the past year and an insider’s close-up examination of Kaiser Permanente’s current financial status.

The financial numbers, as of third quarter 1999 results, revealed significant accomplishments in reversing the historic financial losses KP suffered in

1997-98; but they also pointed to persisting barriers to a robust, long-term recovery. Those include, especially, failure to bring down high hospitalization trends in some regions and Programwide, double-digit annual increases in pharmacy costs for the foreseeable future (see Figure 1), a result in large part of geometric annual increases in direct-to-consumer drug advertising, now approaching \$2 billion a year. In a nutshell, the numbers suggest that if KP is to generate the large sums needed for medium-term investments in facilities and clinical information technology, the hill that remains to be climbed is still a steep one, and factors like improved hospital and pharmacy management will be critical accelerators.

Another reality evident in Dr Crosson’s financial snapshots: KP can no longer depend, as it long did, on a highly favorable rate position in the marketplace for needed membership and revenue growth. Given the necessity of steep rate increases in recent years, the KP price advantage that traditionally ran in the double digits in California and elsewhere is descending into the low single digits. This reality, he said, combined with Permanente Medicine’s commitment to quality, has, in effect, left the Program with little choice but to shift its value focus from the old emphasis on low price to today’s emphasis on superior quality and service (with competitive pricing) as the key differentiators. Since consumer research has concluded that in the public’s mind, clinical quality is a given—assumed by the public to be a characteristic of virtually all modern American health systems—the most powerful remaining value factor for members becomes the quality of member and patient service, which patients often equate with clinical quality.

As Dr Crosson concluded: “I said it last year (at the Federation’s interregional conference) and I’ll say it again: It’s really pretty simple from the members’ perspective. It amounts to this: ‘Answer the phone; meet my needs; and treat me with dignity and empathy.’ If we do those things, we will succeed. If we don’t do those things, then no matter what else we do, we will not succeed.”

With that as preamble, the remainder of the meeting was a headlong plunge into the best of what all the Permanente Medical Groups have learned about successful practices in member service—especially access and the care experience—and hospital and pharmacy utilization.

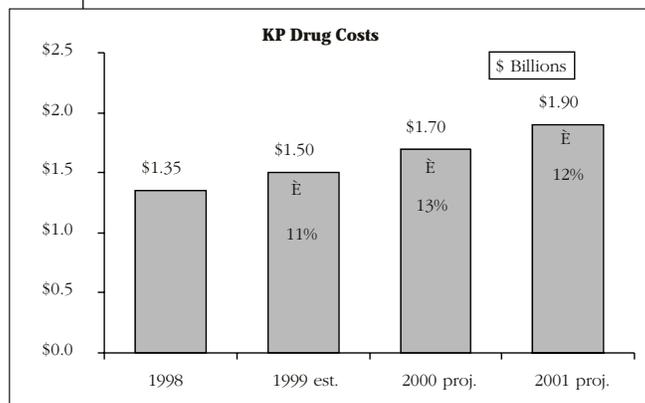


Figure 1: Rising Health Care Costs: Drug spending increases outpace all other categories of health care spending



### The Gospel According to Terry Stein: Communication at Core of Care Experience

Terry Stein, MD, has been talking about physicians talking, and listening, for more than ten years as Director of Clinician-Patient Communication (CPC) at The Permanente Medical Group. She is passionate on the subject, and her passion—and her data—is compelling. As Chair of the Interregional CPC Leadership Group, she has lately been broadcasting her key message far and wide across Kaiser Permanente: “The clinician-patient relationship is at the heart of the care experience”—meaning that patients want to be heard, listened to, cared about, understood, and involved in their own care decisions. When clinician-patient communication works, she says, the data show that patients are more satisfied, adherence to treatment plans increases, health outcomes improve, physicians are less likely to be sued, and physicians themselves are more satisfied.

Dr Stein delivered the conference’s keynote presentation—a sweeping review of the growing body of data on three interrelated questions: How does the clinician-patient relationship fit into the overall care experience; what do we know about the relationship between communications and health outcomes; and how have CPC education programs affected patient satisfaction. She concluded with a look at the opportunities for KP represented by improved CPC performance and an assessment of the effectiveness of existing CPC training programs, such as TPMG’s “Communication Skills Intensive” and “Thriving in a Busy Practice.”

Here’s a sampling of the data presented:

#### What do patients want?

- Northern California STAR data reveal that two factors—a patient’s perception of the familiarity of the care provider, and the perception of having chosen one’s own provider—account for about a 20 percent difference in overall patient satisfaction when all other factors are equal (see Figure 2). “There’s clearly a human need,” said Dr Stein, “to be known and seen as an individual and to have exercised one’s own autonomy in this very crucial human relationship.”
- Other important data from external sources include: A 1998 literature review on patient priorities in primary care<sup>1</sup> concluded that “Humanness”—defined as “respect and

personal interest in the patient as an individual”—outranked 27 other priorities, including such high-profile aspects of care as wait times, financial accessibility, and even improvement in one’s health.

- From a 1999 Patient Satisfaction and Outcomes Management study<sup>2</sup> the top

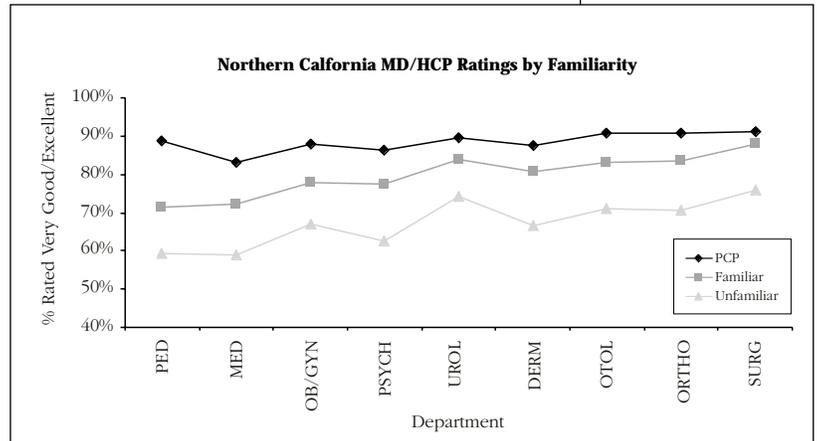


Figure 2. The familiarity effect is replicated in many departments—with ratings up to 30% higher if patient sees his/her own provider vs. seeing an unfamiliar provider and up to a 20% difference between a familiar and an unfamiliar provider. (Adapted and reproduced from Gregory K. Regional report: The importance of patient familiarity with provider to care provider ratings. Northern California Region Member Patient Satisfaction Survey. Oakland, California: Kaiser Permanente Medical Care Program; 1998.)

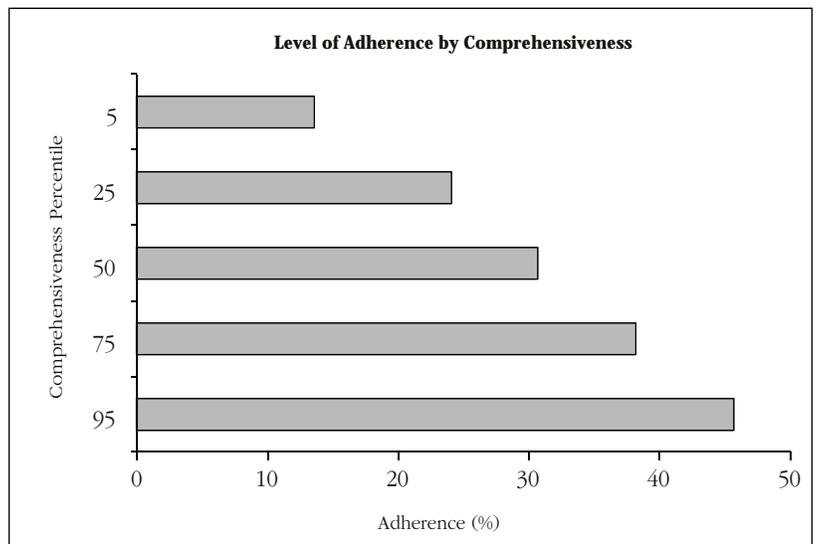


Figure 3. Adherence scores derived from multivariate regression results. Model adjusts for patients’ sociodemographic characteristics and health status. Results reflect levels of adherence as comprehensive contextual knowledge scores are systematically varied, holding all other variables constant at their mean. Safran et al; 1998.




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patient expectation is to receive information and have the doctor listen. A 1999 article from the HSM Group, on strategies for improving health plan retention,<sup>4</sup> concluded that the patient-physician relationship usually is the most critical factor in member retention and loyalty, regardless of the product or delivery model.

***The link between CPC and health outcomes:***

- A 1998 study,<sup>5</sup> found that adherence rates were 2.6 times greater when physicians’ “whole person” knowledge of patients was strongest (see Figure 3).

***The link between patient satisfaction measures and CPC:***

- A 1996 study<sup>6</sup> concluded (ironically, in light of public paranoia about managed care’s alleged limits on medical tests) that patient satisfaction correlates significantly with patient perceptions about the provider’s humanism but not with meeting patient expectations for tests.

***The link between CPC and clinician satisfaction:***

- A 1993 study<sup>3</sup> found that the highest single source of career satisfaction for physicians was “enjoyment of relationships with patients.”

“The message,” said Dr Stein, “is very clear: What patients want is humanness and the personal interest and attention of their provider. These things are at the top of the list. And because patients tend to equate ‘quality of care’ with the quality of the interpersonal treatment they receive, the fastest way to increase the quality factor in the health care value equation is to put much more attention to this area than we have previously done.”

Toward that end, the Interregional CPC Leadership Group recommends that all PMGs pursue the following steps:

- Provide educational programs, such as TPMG’s “Thriving in a Busy Practice” and 5-day “Communication Skills Intensive,” for improving CPC skills, especially for all newly hired clinicians;
- Provide intensive training for clinicians with significant patient satisfaction problems;

- Continue surveying members routinely on satisfaction with medical visits;
- Provide performance feedback to all clinicians, with consequences for substandard performance which does not improve;
- Recognize and reward superior CPC performance;
- Include CPC competency assessments in physician recruitment;
- Make CPC training voluntary, but performance mandatory.

“What this all adds up to,” said Dr Stein, “is that we have a tremendous opportunity at Kaiser Permanente—perhaps greater than any organization in the country—to offer our patients and members this kind of humane, personal, empathetic, collaborative care that they clearly want. The problem is that in our current state, we are a long way from delivering that kind of care experience.” The challenge, she concluded, is “not just a matter of correcting some deficiencies but of striving for a new level of excellence.”

**Managing Access to Improve Patient Satisfaction**

No one in Kaiser Permanente, and perhaps no one in America, knows more about the link between the care experience and access to care than Marv Smoller, MD, KP’s “godfather of access,” according to the Federation’s quality chief and a conference coleader, Jed Weissberg, MD. Dr Smoller, a TPMG physician who has consulted throughout KP on access improvement initiatives, noted that access—the ability to schedule a timely appointment with the provider whom the member chose with a minimal phone wait—has been a major hurdle in terms of patient satisfaction since the very inception of prepaid health plans, which significantly increased (by almost a third) the number of member primary care visits per year. “The question is,” said Dr Smoller, “Can a supply-demand model help improve the situation?”

Smoller’s model, based on analysis of years of appointment demand and availability data, shows that “demand is predictable.” The number of clinical calls and visits for a given number of members has held steady for years at about 4.33 visits per year per 10,000 KP members, nearly all for primary care. In addition, he noted, the demand is predictable in terms of three major types of visits: same-day, return, and physical examination, and the predictability for each can be expressed in terms of days, weeks, and months of the year. “In addition,” he



noted, “providing good access and good service does not increase the demand. It is stable.”

To meet that demand, Smoller emphasizes the following supply-side requirements:

- Clinician scheduling: “Getting this right is critical, and it can be done” through good leadership, cultural change, and advance vacation planning.
- Simplify appointment types: Some programs categorize appointments by as many as 30 different types in trying to perfect a scheduling system, only to complicate things hopelessly. “Stick with the three basic types.”
- Develop an effective return appointment system to prevent the problem of “pre-books” creeping into the same-day allotment, and address clinician cancellations through strong leadership and a culture of personal responsibility.
- Reduce the number of after-hours care appointments by extending the clinic day to permit late afternoon or early evening appointments.
- Collect and provide accurate data for feedback to clinicians and care teams.

“I strongly believe,” said Dr Smoller, “that good access and service is possible, but it requires two things in addition to all this: consistency—it has to happen every day, not just sometimes—and leadership.”

### Best Practice Models in Access, Care Experience

Among the many successful practices presented by panelists exploring access and the care experience, attention focused repeatedly on a few outstanding models of workforce and member/patient satisfaction improvement programs. They included Hawaii’s “Path Forward” strategic cultural shift; Georgia’s primary care access model, the core of a broader patient satisfaction commitment; and SCPMG Orange County’s “Access Is Job One” primary care access model.

Although each model is distinctive in many ways, presenters noted that all three have been built up from scores of incremental steps, or building blocks, and the Georgia and Hawaii models have been evolving for many years. “The first learning,” noted Debra Carlton, MD, who discussed the Georgia model, “is that there is no magic bullet.” Also, all have shared other key success factors, including:

Georgia Region: STAR Care Index Measures of Member Satisfaction 1991-2Q 99 YTD

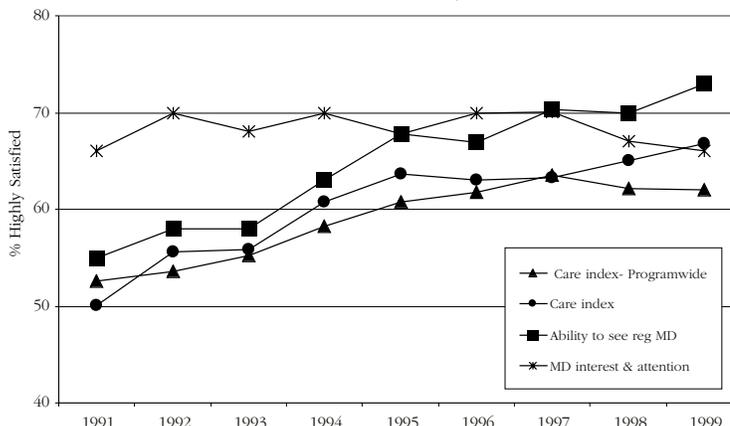


Figure 4.

Overall Access % Highly Satisfied

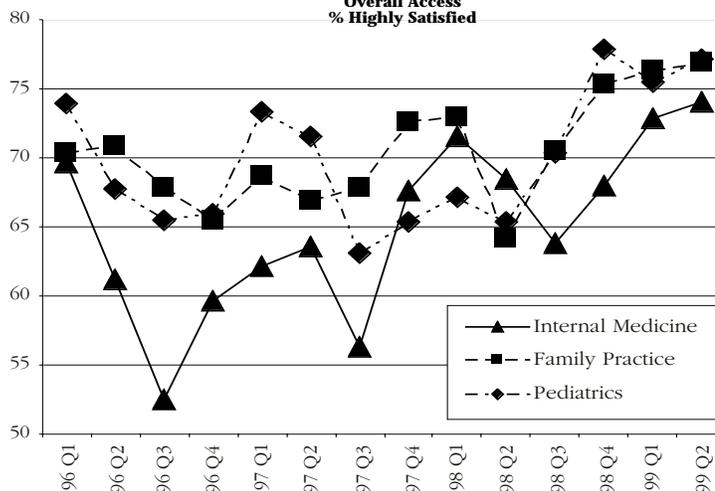


Figure 5. Ambulatory Care Questionnaire Survey, Anaheim, CA.

Hawaii Region: STAR Care Index Measures of Member Satisfaction 1991-2Q 99 YTD

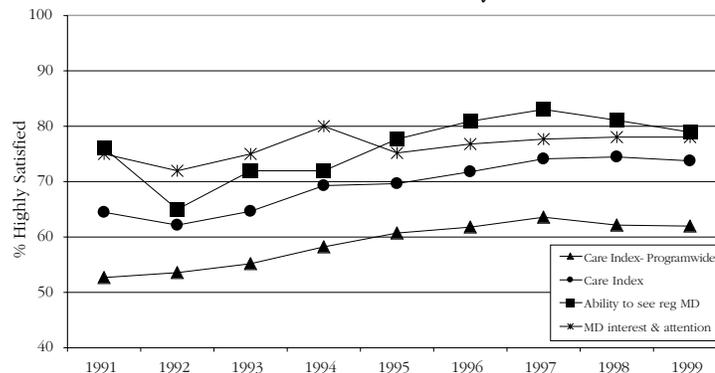


Figure 6.




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*“... all the successful models have produced impressive results in terms of sustained improvement in their STAR Care Index measures ...”*

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- A focus on members choosing and seeing their own primary care physicians,
- Leadership that is focused on and committed to member satisfaction,
- Accountability at all levels,
- Actionable measurement and feedback on patient satisfaction,
- Well-trained, empowered, and supported health care teams,
- And, in access improvement efforts, accurate appointment demand forecasting with daily monitoring and adjustment.

At the same time, significant differences exist among the successful models. Orange County, for instance, makes significant use of financial incentives for patient satisfaction at the health care team level, as does the Georgia model, while Hawaii avoids them entirely. Orange County achieves clinical staffing flexibility through the use of per diem physicians, which are not used elsewhere.

But most important, all the successful models have produced impressive results in terms of sustained improvement in their STAR Care Index measures, including such key measures as “ability to see regular physician,” “physician interest and attention,” and wait times for appointments (see Figures 4-6).

“These models show us that we can make great strides in making the care experience a key driver of value wherever we have strong leadership and a will to improve,” said Jill Steinbruegge, MD, the Federation’s Associate Executive Director of Physician Development and a key conference organizer. “They also show that, as Jay Crosson said, it really isn’t all that complicated. The real key is developing the leadership to make it happen.”

Detailed descriptions of the components and evolution of each model were presented both in written form and in panel discussions, which focused on the question of adaptability and transferability. (Permanente physicians may obtain copies of written materials from The Permanente Federation’s Communications Department, 510-271-5983. Select materials will also be posted on a Web site being constructed by the Federation, accessible through the main KP Intranet, KPNet.)

### **Resource Management: Hospitals and Pharmacy**

The final sessions of the conference shifted gears from access and patient satisfaction strategies to examine some ambitious initiatives in various regions aimed at improving quality and costs through innovative hospital and pharmacy utilization management programs.

Cal James, President of The Permanente Company, which has examined the best practices in both areas, noted that the growing use of hospitalist programs in KP regions has generated enthusiasm in some quarters while failing to provide conclusive evidence of effectiveness in all situations. Although there is good evidence of added value (improved patient satisfaction, quality, and utilization) in the use of hospitalists at contracted, non-KP community hospitals, he said, the data on hospitalists in KP hospitals is mixed: Some programs have documented major gains while others have been disappointing or inconclusive. Despite the mixed experiences, James noted that a few common success elements stand out, especially the importance of physician buy-in to hospitalist programs and effective communication among PCPs, hospitalists, and patients—factors noted by virtually all the presenters.

The clearest success story is Colorado PMG’s 2-tiered triage admission program, championed by Assistant Medical Director Victor Collymore, MD. In place since 1995, this program depends on three different types of hospitalists to screen admissions: a triage physician who evaluates all admissions by telephone, rounding physicians who do on-site evaluations in the ER and rounds of 8-12 patients daily, and call physicians who clinically evaluate admissions as directed by the triage physician. This type of triaging has helped the Denver/Boulder area achieve the lowest Medicare days/1000 of all KP Regions, and the second lowest Commercial days/1000 (see Table 1).

Jeffrey Selevan, MD, Manager of Operations for SCPMG, described a more limited but equally successful program aimed at out-of-plan hospitalizations in more than 120 non-KP hospitals in Southern California. Called the Affiliated Intensivists Network (AIN), it contracts with two independent vendors that subcontract with large networks of physicians at non-plan hospitals, all of whom must meet SCPMG’s credentialing requirements. These affiliate intensivists evaluate all KP member admissions and can discharge KP members from non-plan emergency departments or transfer them to KP hospitals if they are stable. Preliminary results have been encouraging: Admit rates and lengths of stay have decreased significantly in non-plan hospitals, member satisfaction is high, and annual savings could approach \$15 million if the study sample is representative of all cases managed at the AIN-covered hospitals.



Less encouraging results were reported from hospitalist studies in Northern California and San Diego. Stony Anderson, MD, SCPMG Chief of Internal Medicine, declared that "The hospitalist is not the goose that lays the golden egg," after a study concluded that a hospitalist program in San Diego would cost \$2.3 million a year (compared with traditional rounding) without showing any gains in quality measures or physician satisfaction and with only marginal improvements in nurse and patient satisfaction. In Northern California, Diane Craig, MD, Assistant PIC, noted that various hospitalist models have been used throughout the region without having significant impacts on regionwide patient days, readmission rates, or patient satisfaction. Anecdotal evidence, however, has been encouraging, especially in terms of increased efficiency

in the continuum of inpatient care, increased clinic time and outpatient visits for PCPs, and valuable experience gained in the management of inpatient care.

Turning to pharmacy management programs, James reviewed the astronomic recent increases in overall drug costs and the impacts of direct-to-consumer drug advertising, up 43% during 1998, and encouraged physicians to "strap on the bayonets" for all-out battle against pharmaceutical advertising. Major weapons in the battle, said James, should include physician peer review with unblinded pharmacy utilization data, sharing of national data to identify reproducible best practices, and promoting proven counter-detailing strategies, such as increased pharmacy education programs. Panelists offered presentations on each of these strategies. ❖

*(Note: Audiotapes of Dr Stein's presentation on the role of Clinician-Patient Communications in patient satisfaction are available from The Permanente Federation. Contact Samuel Yates, 510-271-5983, or e-mail samuel.yates@kp.org)*

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**Table 1. Colorado Region's 2-Tiered Triage Program**

	Jan 1995	Jan 1999
Discharges/1000		
Commercial	45.90	41.00
Medicare	224.60	176.20
Mean Length of Stay		
Commercial	3.95	3.30
Medicare	5.20	4.07
Days/1000		
Commercial	181.60	135.20
Medicare	1161.60	717.90

Successful triage has resulted in the reduction of hospital days/1000. Denver/Boulder had the lowest Medicare days/1000 of all Kaiser Permanente Regions; 2nd lowest Commercial days/1000

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