



Permanente Medicine:

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A Conversation With Jed Weissberg, MD, On Defining Permanente Medicine

(Jed Weissberg, MD, is the Associate Executive Director for Quality and Performance Improvement at The Permanente Federation, where he has led efforts to better understand the meaning of Permanente Medicine. Before joining the Federation in February 1998, Dr Weissberg served as PIC at the Fremont Medical Center in Northern California. Interview conducted by TPJ Communications Editor, Jon Stewart.)

The Permanente Journal: Dr Weissberg, when you joined The Permanente Federation, one of the first things you did was initiate a systematic approach to defining and talking about Permanente Medicine. Why was that such a priority for you?

Jed Weissberg, MD: Actually, I'd never heard of Permanente Medicine before I came to the Federation. But Jay Crosson (Executive Director of The Permanente Federation) and everyone else there was talking about "Permanente Medicine" and "Permanente Practice" as if it were common knowledge. So after about a week, I finally got up the courage to ask Jay, "What's this thing you call Permanente Medicine?"

Well, it turned out he had a very clear idea in his own head of where this all went, but he was thinking mostly in terms of the structural and accountability issues inherent in the Permanente Medical Groups—things like self-governance, self-management, and group responsibility. Those are the essential principles by which Permanente Medical Groups have organized themselves and held themselves accountable, and they really do seem to define what's unique about the way we organize ourselves. But when some of us sat down and tried to flesh out those concepts in terms that would have a more emotional reality, we realized that there had to be another side of the picture, one that represented the clinical and patient side in addition to the organizational qualities. And that's what we've come to call the "performance principles" of Permanente Medicine—quality medicine, the Permanente-Patient relationship, and resource management. These concepts, of course, are all interrelated.

TPJ: Why is it important to articulate these principles? Haven't they been operative all along without a formal definition?

JW: Well, remember that Sidney Garfield, who started this whole thing, defined what he thought was unique about the Permanente way of organiz-

ing and delivering medical care. We're all familiar with those elements—what we call the "genetic code"—things like prepayment, group practice, prevention, comprehensive coverage, and physician responsibility for medical care. But as the program expanded into new regions, various medical groups started introducing variations on themes in terms of incentives and approaches to care and their own kinds of delivery systems. I think we still had the impression that we were basically different from everyone else and similar to one another, but it was getting harder to articulate that that was the case. It may be true that for a long time it didn't really matter, but by the 1990s, when everyone else was trying to do "managed care," we got to the point where we really did need to differentiate ourselves from all the rest of managed care, which was taking such a bashing in the press. That meant that we needed to have a clearly defined identity. We needed to really understand among ourselves—and then communicate to others—what it is that makes us different.

TPJ: It wasn't just the mass media doing the bashing. The professional press was attacking some of the underlying principles of Permanente Medicine, as well.

JW: Yes, like those articles in the *New England Journal* that were criticizing the so-called "distributive ethic" of prepaid group practices. They were saying basically that physicians could not provide optimal care for each of their individual patients and for the entire



Jed Weissberg, MD, uses the Permanente Map to define Permanente Medicine to a group of Permanente physicians. (See map and related story, page 32.)

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population of patients under the group's care at the same time. They implied that prepaid group practice physicians had become "double-agents," acting on behalf of the health plan, or of third-party payers, instead of on behalf of their patients. And they were saying that population-based care means deliberately providing poorer care for some patients than for others.

These were very powerful messages, coming from a powerful professional journal, and they went to the very heart of Permanente Medicine, the ethic of prepaid group practice. So, in some ways, what we were doing in trying to articulate the principles of Permanente Medicine was to restate our claim to professionalism around a core set of ethical beliefs. I suppose it was not unlike the challenge that Garfield and the other pioneers of Permanente Medicine faced from organized medicine back in the 40s and 50s.

TPJ: It's interesting that this initiative also came about at a time when the medical groups were reorganizing themselves at the national level vis-à-vis the health plan. Was that relevant?

JW: I think so. This new emphasis on understanding the uniqueness and the strength of Permanente Medicine coincided with the creation of the Federation, which had enabled much more interaction among the medical groups throughout the program than had ever before existed. And I think the Permanente leadership saw that there were actually some pretty significant differences among the regions in the ways they were delivering care—especially in some of the regions that were having difficulty. This naturally made the leadership want to figure out what was working and what wasn't. And of course much of the weakness was in areas where the delivery system was at variance with the principles that made

The Principles of Permanente Medicine

The ongoing effort to articulate the basic principles and dimensions of the professional identity and practice style known as Permanente Medicine has resulted, to date, in the following definitions:

Group Responsibility:

Physicians sharing a group ethic that promotes shared responsibility and accountability for the care of individual patients and an entire member population in a capitated environment

- Group Capitation—Prepayment for healthcare services allows physicians to be prudent stewards of healthcare resources
- Dual Responsibility—Physicians are responsible to the individual patient and to the membership for providing quality care and service that is affordable
- Multi-specialty Collaboration—Physicians work together to ensure the total health of our members using a shared medical record
- Professional Development—Culture that is dedicated to life-long learning in the art and science of medicine, and in the management of a high quality care delivery system

Self-Governance:

Physicians determine Medical Group policy through elected, representative physician leadership

- Partnership—Physician peer relationship that encourages participation in Medical Group affairs, builds greater commitment to quality and supports a long-term perspective
- Representative Decision Making/Due Process—Physicians have a right and a responsibility to contribute to group decisions
- Physician Leadership Development—Physician leaders and future physician leaders develop the necessary skills to provide the best leadership to the Medical Group at every level of management
- Ethical Compensation—Salaried physicians and other compensation practices that support physicians in making the best clinical decisions for patients
- Access to Capital—Capital is required for investment in new technologies, facilities and improving the delivery system to continue to meet the needs of our membership

Self-Management:

Physicians direct all clinical decisions and the design and operations of the care delivery system

- Care Teams—Physician-led, multidisciplinary care teams bring together expertise to meet the diverse needs of our members
- Management of Medicine/Operations—Physicians formulate all clinical policy and actively participate in the design of every level of our care delivery system
- Co-Management of Business—Physician leaders partner with health plan executives in making critical operational and business decisions
- Performance Improvement—Physicians directly oversee and measure key aspects of the care delivery system and analyze variation, which fosters innovation and improvement

us strong in our core markets. There was a sense of needing to get back to first principles—but first to figure out what they were.

TPJ: That was also a time when the leadership in Oakland was developing what is now known as the KP Promise, or brand strategy, which puts a lot of emphasis on positioning KP as a high-quality, service-oriented delivery system. Is the KP Promise compatible with Permanente Medicine?

JW: Very much so, fortunately. Because I think the KP Promise, with its focus on quality medicine, really did grow out of an understanding of the organization's traditional strength, which is the physician-directed delivery system. The KP Promise includes that notion of physician responsibility, which is at the heart of what we call "group responsibility" and "self-management" in Permanente Medicine. And the Promise is also built around the performance side of

the Permanente Medicine paradigm, with its emphasis on quality medicine. In fact, in some ways, the KP Promise might be said to represent the third, invisible side of the Permanente pyramid, with the structural principles and the performance principles on the other two sides. What is different about the Promise is that it incorporates perspectives that have not been articulated as aspects of Permanente Medicine, such as the essential role played by our employees and the interests of KP members. The Promise blends those interests more explicitly than the principles of Permanente Medicine, which are more self-reflective from the medical group point of view.

TPJ: What was the process you followed in identifying and defining the principles of Permanente Medicine? How much input did you get from beyond the 27th floor (the Federation Executive Offices in the Ordway Building in Oakland)?

- Peer Review—Physicians/Staff receive feedback and training on clinical and service performance based on continuous peer review and member feedback

Quality Medicine:

Health care experiences and outcomes that set the quality standards for American medicine

- Evidence-Based Medicine—Disseminate and implement Program-wide clinical guidelines by sharing best practices and the collective clinical experience of 10,000 physicians
- Integrated Member Care/Service—Integrate care across multiple care settings, populations, life stages, specialties and care teams, using ubiquitous access to clinical information
- State-of-the-Art Clinical Decision Making—Developing a national clinical information system to integrate information at the point of care—facilitating the rapid flow of clinical knowledge using common data elements and terminology
- Preventive Care/Community Health—Promote healthy lifestyles, disease prevention, health risk assessment, education, and communication
- Advancing Medical Knowledge—Fund and perform research, contributing to the continuous improvement of our system of care and medical knowledge

Permanente-Patient Relationship:

Patients, physicians, health care practitioners, and staff work as a team to make care decisions and meet the patients' needs

- Partnering In Care—Patients are given the educational tools and empowered to participate as partners in decision-making and to share responsibility for their care
- Continuity of Care—Stable physicians and entire care teams continue in their practice with little turnover
- Care Based on Trust—Patients are assured confidentiality and our best professional judgment by a structure that gives physicians and patients sole responsibility for care decisions
- Culturally Competent Care—Members' cultural diversity and health care preferences are respected and accommodated
- Support Systems—Operational systems/procedures (patient registration, appointment scheduling technology, Call Centers) provide the environment necessary to foster the Permanente-Patient Relationship

Resource Management

Physicians determine appropriate use of members' resources across multiple care settings to improve the health outcomes of our membership and ensure affordable health care

- Utilization—Physicians and members together control the entire episode of care, which enables us to determine the appropriate care in the appropriate setting at the appropriate time
- Staffing—Use physician-led care teams to leverage the skills of physicians and other health care practitioners to effectively meet needs of member
- Cost of Care—Provide effective and efficient diagnosis and treatment by reviewing patterns of care with the aim of improving quality and eliminating waste



JW: A lot, ultimately, and we're still working at it. But it needs to be said that Jay Crosson and a handful of Federation staff people did a lot of the early conceptual work, and most of it has stood up under pretty intense reexamination—especially those three structural principles that Jay identified: group responsibility, self-governance, and self-management. People will argue about the exact labeling, but there's a lot of consensus around the meaning. And, of course, even those principles were really an outgrowth of elements of the genetic code, so the debt goes back to Garfield.

What I started doing was collecting a lot of mission statements, orientation materials, and strategic plans that various PMGs had worked on, where they had tried to identify basic principles of practice. The Colorado PMG had a very well thought out set of principles, and so did some others, like Georgia. It was surprising how similar those principles were, even though the groups had never shared them before. So we tried to identify the common threads among them and then feed them back to regional leaders and various reactor groups, including the Permanente Executive Committee and the day-long Permanente Medicine roundtable discussion in Colorado, where virtually every PMG was represented (see "Permanente Medicine Roundtable" article, p. 45).

Over the last couple of years, between Jay Crosson and myself and a few others, we've talked to dozens of groups—mostly physician groups—about Permanente Medicine. Every time we do it, the definition takes on a little more clarity. We keep testing it and looking for ways to make the definitions operationally useful, such as in the performance analysis and improvement work we do. And, so far, we've gotten remarkably positive feedback. People really like to talk about it, I think because it provides a common language for understanding some very complex ethical issues that are common to all of us.

TPJ: It's easy to see how this work can be useful in terms of differentiating KP from the bad guys of managed care in the pub-

lic arena, but how is it useful internally and operationally? How does it relate to the day-to-day provision of medical care?

JW: What these principles do is give us a framework for holding ourselves accountable to one another and to our patients for the things we say we believe in. If these principles really define our professional beliefs about the best way to provide health care, then we need to translate them into objective measures of accountability. We need to be able to say, "We practice what we believe in, and here's the data to prove it." So a lot of the work of defining Permanente Medicine has been defining objective measures for each of the principles, especially the performance principles around quality and resource management, but also the structural principles like self-governance and self-management. Do we really govern ourselves through representative leadership and due process? Does every PMG have the appropriate structures and processes in place for self-management and resource management? And can we point to appropriate outcomes measures as evidence of our accountability?

Remember, the medical directors of all the PMGs have agreed to hold one another mutually accountable for all performance—clinical, service, everything. That agreement really gave new meaning to the notion of "flying the Permanente flag." If we're going to call ourselves Permanente Medical Groups, that has to mean something specific and measurable, and Permanente Medicine gives us the conceptual framework for developing those specific measures. This part of the work is now in the hands of a number of national and interregional work groups, such as the KP Performance Review Committee, which recommends performance measures to the KP Partnership Group, the organization's top management group. The Care Experience Council is doing another key part of the work, focusing on measures of access and service.

TPJ: Those groups are all joint Permanente-Health Plan groups. But apart from that connection, where does KFHP fit into Permanente Medicine? Or doesn't it? Can you have Permanente Medicine without Kaiser Foundation Health Plan?

JW: That question borders on treason. But thanks for asking it, anyway. Because in all truth, you're not the first. It's a legitimate question that's worth exploring. However, in our current conception, KFHP has been an integral part of our understanding of Permanente Medicine ever since we started looking at it. Before I ever got involved, Jay Crosson talked about the principles of Permanente Practice existing within the context of an exclusive partnership with a not-for-profit health plan, and around here that means KFHP. Without that partnership, it's hard—maybe not impossible, but much harder—to imagine how Permanente Medicine could stand alone. I think the partnership adds a lot to the overall equation that makes up Permanente Medicine. ❖

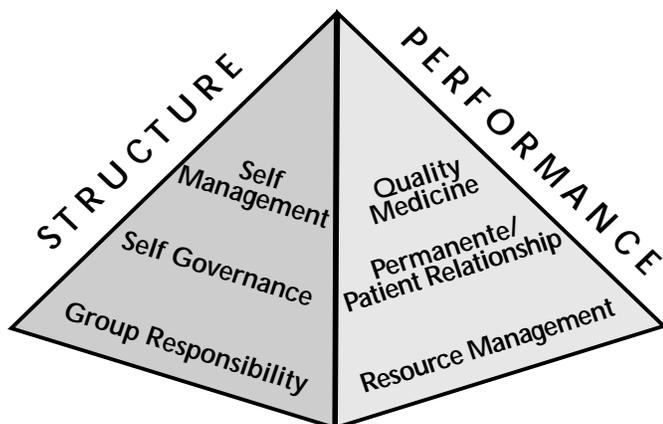


Figure 1. The Permanente Pyramid: The Principles of Permanente Medicine



The Permanente Medicine Roundtable: Defining our Practice Principles

The following conversations have been edited from a day-long Permanente Journal roundtable discussion on Permanente Medicine held in Denver in late 1998. Participants included Lee Jacobs, MD, Associate Medical Director, TSPMG; Genie Komives, MD, then-Acting Director of the North Carolina PMG; Don Parsons, MD, Associate Executive Director of the Federation; Les Zendle, MD, Associate Medical Director, SCPMG; Al Mariani, MD, Chief of Surgical Services, HPMG; David Shearn, MD, Director of Physician Education and Development, TPMG; Jed Weissberg, MD, Associate Executive Director of the Federation; Andy Wiesenthal, MD, Associate Medical Director, CPMG; Walid Sidani, MD, Associate Medical Director, OPMG; Marty Lustick, MD, Associate Medical Director, MAPMG; Paul Wallace, MD, Director of the Clinical Practice Guidelines Program in the Northwest; and Federation staff members Leslie Francis, Sally Stephens, and Jon Stewart.

Why Define Permanente Medicine?

Les Zendle: This work is not only a good opportunity to do some external communication about who and what we are, but it's also a way of dealing with some of the morale or ethical issues Permanente physicians are facing. There is so much media and public discussion about "managed care," and it focuses on anecdotal "horror" stories, which are not representative of the quality of care provided by Permanente physicians. More clearly defining Permanente Medicine could counter some of that, both internally and externally.

Al Mariani: There are horrible free-market abuses going on in health care, especially by our for-profit competitors. It is essential to the survival of Kaiser Permanente that we find a way to differentiate ourselves from them. Not only from the for-profits but also from the staff models where the physicians work *for* the health plan. In our group model, we work *with* the health plan. We need to promote the value of the independent, prepaid medical group model in the national consciousness. It represents some essential qualities that few people outside of the organization—and a lot of people inside of it—don't appreciate.

Walid Sidani: A definition of Permanente Medicine is sorely needed. It should permeate several activities and could enhance our ability to communicate, in a common language, our values and principles. We should use it in our recruitment and orientation efforts so that candidates and new physicians know what is expected of them.

Marty Lustick: I think one of the critical pieces of this work is to answer the question: What is it about Permanente Medicine that distinguishes us from the rest of the world and allows us to work out some of

the tensions and the ethical dilemmas that confront physicians in the era of managed care? If we can clearly demonstrate and communicate that our solutions to these dilemmas are the most meaningful ones for this society, that's going to be a critical message.

Lee Jacobs: I think we need to be clear that we're not creating anything new. We're just defining what's been there all along—what makes us unique. I would also emphasize that the language we use is critical. We all use terms differently, and we may mean the same thing or we may not. It would be helpful if we could end up dealing with the language so that we could all use the same terms and know what we mean when we talk about Permanente Medicine. Language is very powerful.

Genie Komives: I agree about the language. But the discussion documents we're dealing with—the work that's already gone on in this project—do include some new ideas. For instance, this work gets into setting some really concrete metrics to decide whether or not we're living up to what we've defined. I see the potential for a sense of threat in there—like, if you don't measure up, you're no longer a Permanente Medical Group. I don't know if that's necessarily what we want to convey.

Lee Jacobs: I think we need to present Permanente Medicine in such positive and meaningful terms that everybody in the Program will want to be on board. No one would say, "That's not me." That's how we overcome the potential for this to sound like a threat.

Jed Weissberg: Good point. But maybe there's a dark side to this. What if you don't make the grade? Or what if there are issues of divestiture, as there have been in parts of the Program? And what would constitute Permanente Practice even outside a relationship with a Kaiser Foundation Health Plan? These issues get to another question, which is: Should this definition describe our current state or our future, aspirational state? That's especially relevant when we talk about what constitutes "quality medicine," which is one of our performance principles.

Genie Komives: To the extent that we've not necessarily done a good job of communicating what we are, there's an aspirational and demonstrational quality to this work. But that doesn't necessarily mean aspiring to be different than we are. We often feel like we're there in terms of quality goals, but we just can't prove it.

Marty Lustick: I think in some ways it is also a value statement, which hopefully describes who we are, what we aspire to be, and the standard we hold

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*"It may be that Permanente and Kaiser are so intertwined in our definition that it's not Permanente Medicine without Kaiser."
— Lee Jacobs*

for ourselves. Defining Permanente Medicine is part of what we are. It's actually having a set of standards that we hold everybody to and committing to the environment of the learning organization.

Does Permanente Medicine Depend on Kaiser Permanente?

Jed Weissberg: When Jay Crosson (Executive Director of The Permanente Federation) started talking about the basic structural principles of Permanente Medicine, or Permanente Practice, he was talking about it in the context of a not-for-profit health plan. The issue is being revisited in this effort to better understand what it is about Permanente Medicine that makes it unique. Because, with some groups looking at possible divestiture, it may be necessary to explore whether you can practice Permanente Medicine in a different context.

Les Zendle: The issue of practicing Permanente Medicine outside the context of a not-for-profit health plan is not the discussion that worries me. I have to say that I don't particularly want to practice Permanente Medicine without *this* particular not-for-profit health plan—Kaiser. To me, they have to be practiced together.

Jed Weissberg: But some Medical Group leaders nonetheless feel the need to have at least the intellectual experience of thinking this through. This is a brave new world, and we have to give ourselves some intellectual space to explore these concepts.

Lee Jacobs: It may be that Permanente and Kaiser are so intertwined in our definition that it's not Permanente Medicine without Kaiser. I'm not sure that's the case, but I'm saying we need to have that discussion. Basically, I agree with Les that I wouldn't know how to practice Permanente Medicine without the business competencies that Kaiser brings to the definition. I don't think we could do it without them.

Marty Lustick: I think that focusing on what Permanente Medicine means in the absence of Kaiser actually serves two positive roles. One is that it helps us understand where the gaps are in our performance and what we need to do to improve, no matter what happens in the larger partnership. But also, it ultimately makes it less likely that we'll have to deal with that possibility; whereas if we don't plan for it, the likelihood of it actually happening may increase. If the partnership is going to thrive in the long run, we have to look at standing on our own two feet. To the extent that we're successful at driving our own performance as a medi-

cal group, it becomes less likely that we'll have to go outside the partnership.

Paul Wallace: We have to be careful about what we mean by "Kaiser." There's Kaiser the corporation, but there's also a set of values that are implied by that name. Look at the relationship with Group Health. There have been tensions around the affiliation, certainly, but there's a very close parallel with our values and theirs. I think it remains conceivable that a Permanente Medical Group could have a very similar relationship with a different organization so long as it had similar values.

On the Key Principles of Permanente Medicine

Lee Jacobs: I would say there are three principles that are key. Number one is physician leadership, which should be a stand-alone bullet, top of the list. That's distinguishing. Self-governance is just an aspect of that, not a separate principle. The second one is the idea that we are the best advocate for patients—however you wordsmith it. And the third thing is the group ethic. It's essential to what we are.

Marty Lustick: I think that more than anything our group ethic distinguishes us from the rest of the world as a kind of protection against making the wrong responses to these ethical issues we all face. Because we're part of a large group, we have to struggle and come up with meaningful answers to these questions. We actually do hold each other to a standard, whatever that standard is. For instance, we struggle over any little innovation in our compensation system, asking how it might affect physicians' decision-making. Private practices don't protect themselves that way.

Al Mariani: Just to carry the argument about physician leadership a little further, I agree that the culture of physician leadership needs to be at the top. The regions that have been the most stable over time are the ones that were steeped in that culture. Leadership really is the center. And this isn't fuzzy rhetoric. I'm talking about coming up with \$100,000 or whatever to run a peer-to-peer survey or a quality-of-service survey, or all the other measures that we do on the really basic things. By measuring them, you send a message to the front-line that this is what the leadership expects; this is what we'll measure. And then, a real leader has to have the courage to do something about the outcomes. That needs to be our culture—defining the essential things, measuring them, and then acting



on the outcomes. Our medical group structure gives us the ability to do that.

Marty Lustick: Another thing that distinguishes us is our ability and commitment to be a learning organization, which is how we are able to achieve all those performance-related principles, like great medicine. Because of the way we're organized—as a large group practice with an information system infrastructure—we have a unique opportunity to be a learning organization in ways that others don't.

Don Parsons: We've talked a lot about the importance of the physician-patient relationship and being an advocate for the patient; and yet, we've been designing adult primary care models based on collaborative care teams where physicians may not in fact have a lot of contact with many of their patients.

Lee Jacobs: I don't think that's incompatible with the patient-physician relationship principle. There has not been much discussion here about collaboration in multispecialty care teams, which is clearly a part of Permanente Medicine. And I don't think that team-based care is at all at odds with acting as the best advocate for patients.

Les Zendle: I'm a huge advocate of advance practice providers on care teams. But in many systems they are used as access "barriers" to doctors. They sometimes aren't being utilized to bring their distinctive competencies to Permanente Medicine. I'm hoping that the primary care models that are being developed augment the relationship between the patient and the physician rather than create a barrier.

Putting the Principles of Permanente Medicine into Practice

Walid Sidani: As we agree on the principles, how do we assure that they are practiced? Our principles may challenge exactly what's happening today, such as team-based care. If what's happening today really is against a principle, then our activities need to change. Most of the time, we expend a great deal of energy developing principles; yet, we don't spend any time really challenging what we are actually doing against the principles. If we state that the physician-patient relationship is a principle, then we need to assure we've defined what that means throughout our medical groups and to our members.

Genie Komives: That's right. As part of the measures and the monitors, we must ask members several questions. Do you feel as though you have a relationship with your primary care physician? Do you feel as though your care is well coordinated? Do

you feel there are any barriers to seeking the care that you need, when you need it?

David Shearn: Genie's point raises an issue about the proposed principles that concerns me. They don't explicitly reflect a bias toward the patient's needs or the patient's preferences or the patient's view. We are discussing what we'd like the principles to say based on our own views, needs and preferences, but the patient's voice isn't here. It might be interesting to actually bring patients into a forum like this and discuss it.

Lee Jacobs: I'd be cautious about that. We're trying to define and articulate who we are. And in fact, what we are may not be the appropriate choice for all patients. We're not trying to model this so it's attractive to patients. I don't think that's what the goal is.

David Shearn: But patients are increasingly redefining the patient-physician relationship. Increasingly, people are using the Internet and coming into our offices having completed a literature search. As a result, they are telling us what treatment they want. Those patients are redefining what it means to be a partner. I think we can respond to this dynamic more effectively than other systems, because, as a group, we can adapt to things like this by coming up with systematic approaches involving the Internet.

Paul Wallace: Yes, that's part of what's been lost in these proposed principles by leaving out customized, coordinated care as a stand-alone principle. The customized part implies a relationship with somebody.

Les Zendle: This fits right into the discussion around alternative or complementary medicine. It's true that in some places patients are demanding alternative medicine. But is alternative medicine or whatever else the patient demands necessarily part of Permanente Medicine? It's a struggle. We have physicians who feel it's appropriate to provide these alternative therapies, while others feel that if we do this, we might as well sell snake oil.

Genie Komives: But we have already defined some principles here that will help us answer these questions by giving us something to evaluate them against. For instance, evidence-based practice is called out as an aspect of the quality principle. Offering alternative medicine may be a patient satisfier, which will improve the patient-physician relationship. But it may not meet the evidence-based medicine criteria. If we line up issues like these against our principles and they don't meet the criteria, then we can effectively explain why they are not part of Permanente Medicine.

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“We need to articulate our unique relationship between a team of professionals and the patient.”
 – **Andy Wiesenthal**

“Evidence-based medicine must be central to what we do. We aspire to practice it, and we create guidelines around it.”
 – **Don Parsons**

Marty Lustick: But these principles we keep discussing, such as the strong patient-physician relationship and quality medicine, these are things that everyone in health care is striving to provide. It’s just so generic that it sounds empty. What is it about the way we’re trying to practice that distinguishes us from the rest of the world? What makes us *Permanente* physicians?

Walid Sidani: The challenge we have is to inflect meaning into what we define as our principles. How does this translate into the medicine we practice every day? I think some of our discomfort is based on the gap we are experiencing between our principles and our practices.

Marty Lustick: What do these principles really mean? For example, when we talk about the patient-physician relationship, I can only conclude that we’ll never achieve the level of bonding between our physicians and our patients that existed in my father’s practice. He visited patients in their homes, and patients received their care only from him. What is our concept of the patient-physician relationship? What does it mean to the marketplace? What do we bring that’s unique? It certainly is not the kind of high-touch, individual, emotional bond that others can provide.

Andy Wiesenthal: We need to articulate our unique relationship between a team of professionals and the patient. Let’s say I’m caring for somebody who has coronary artery disease. Perhaps a care management nurse and pharmacist are helping me manage the patient clinically. In addition, a nutritionist helps the team manage the patient’s diet.

As the physician, I am seen as the lead on this team. However, I’m not Marty’s father; I’m not a lone eagle. I work with a number of other professionals who all contribute through me and with me to take good care of people. And the patient maintains a relationship with all members of our team.

Walid Sidani: Exactly—the bottom line is how the patient experiences that team.

Jed Weissberg: So maybe we should be talking about the Permanente-patient experience, which encompasses the broader relationship between patients and the medical group, which ideally acts as a kind of extended care team.

Living Up to the Quality Principle of Evidence-Based Medicine

Jed Weissberg: With all this in mind, can we justify that we’re practicing evidence-based medicine, as our quality principle would demand? And what are we doing about that?

Don Parsons: Evidence-based medicine must be central to what we do. We aspire to practice it, and we create guidelines around it. But do we actually practice it? If we are going to claim that we live by our principles, we’d better be sure that we’re either living up to it or that we couch the principles in terms of aspirational goals as opposed to reality. I would think that we could be challenged on any one of these points.

Paul Wallace: I guess I’d take a step back and say, look at evidence-based medicine as a tool for achieving quality improvement. So the bigger question is: Are we using the tools of quality improvement that include evidence-based medicine? We have to phrase the question right. Are we really committed to improving our practice using the relevant tools? And I’d say the answer to that is clearly yes. For instance, measuring the variation of rates, say in mastectomies, is a commitment to quality improvement, because we haven’t ignored it. Subsequently, we must commit to ask what the appropriate rate is. I would say that is totally consistent with practicing evidence-based medicine with sort of a colloquial definition.

Les Zandle: Evidence-based medicine means so many different things to different people. To some people, it means that you don’t do something unless you have double-blind randomized control studies that prove that something works. Of course, if we only did things when we had double-blind randomized control studies, we wouldn’t do a whole lot. It’s also used as a reason to withhold certain things or to not do things or to cut costs.

I like the fact that we are constantly looking at data about what we’re doing and the effect it’s having. Our physicians clamor for data. We don’t give them enough data. And there’s nothing wrong with the cycle of physicians looking at data and then questioning its accuracy, especially since nine times out of ten, the data aren’t very accurate. That’s all part of learning and improving.

We also have to be careful when we combine the term “evidence-based medicine” with the term “variation.” No one should expect that we’re going to get rid of all variation in our system or that eliminating variation is even our goal. We need a certain amount of variation.

Networks and Permanente Medicine

Walid Sidani: Where do networks fit in under Permanente Medicine?



Al Mariani: Networks aren't Permanente, but Permanente must plan to manage networks. Permanente to me is a self-governing group of salaried physicians who have an exclusive financial relationship with an autonomous, regional, nonprofit Kaiser Foundation Health Plan. Anything else to me isn't Permanente. Of course, this is just my opinion. However, it is an opinion based upon the long observation that more often than not when these principles are compromised, the organization does not do well. Within the framework of partnership the medical group has the responsibility for guiding the Health Plan to appropriate patient care. This would mean managing the networks for patient service and quality of care for those areas of medicine that cannot be internalized by the Permanente Group.

Marty Lustick: I actually disagree, because they may be part of what we need to look at to assure Permanente's long-term survival. If the population management techniques we're trying to develop are successful, then we'll need to promulgate those techniques into our communities. That's part of contributing to community health. In fact, part of what Permanente Medical Groups can do—and already are doing—is develop infrastructures that manage network physicians, teach them about Permanente Medicine, and support their delivery of Permanente Medicine. I think it's consistent with where our group is going.

Lee Jacobs: We probably have one-third of our physicians in Georgia practicing without any kind of knowledge of Permanente Medicine. But part of Permanente Medicine is managing those relationships and incorporating the care that's delivered into our care delivery plans. It's incredibly restrictive, and in fact, naïve in today's world to think that Permanente Medicine can only be practiced in a totally self-contained model. I don't think there's such a thing anymore.

Al Mariani: I've worked with network doctors for 18 years. While they have uniformly been professionally competent, the relationship was mercenary. Some take advantage of us, and some don't. Their goals are not necessarily aligned with ours—for instance, evidence-based optimal population care. Our careers are tied to the success of our medical group. Theirs are not.

Paul Wallace: I think of it in subsets—the Permanente Medicine we practice within our Medical Groups and the care we delegate, which is really Permanente-affiliated care. But in our increasingly competitive environment, there's the ability to extend more and more of the principles of the Permanente group practice out into the groups that we contract with. In-

creasingly, in our contracting, we're demanding quality measurement and a variety of the accountabilities that we expect from ourselves within the group. To me, the value of Permanente Medicine is to put as much of that into the contract as we can and still get the care we need to deliver to patients.

Marty Lustick: Another way to look at it is to imagine that we were not affiliated with Kaiser. What would we want in order to continue our practice of Permanente Medicine? What would we want our relationships to be with other doctors in the community? Would we potentially bring our expertise in network management to the table?

David Shearn: Luckily, we don't have to resolve what role networks should play in Permanente Medicine today. But one thing I am observing—since I've been involved in these kinds of conversations so many times—is that something's different about our discussion than others I've participated in. We have reached some sort of consensus about our values, and they give us a reference point from which to have this discussion of networks. Not that we've reached a resolution, but knowing more clearly what we stand for changes the conversation, I think, in a better way.

Measuring Permanente Medicine

Jed Weissberg: Now that we've talked about our principles and their application, how would we measure them to exhibit our responsibility and accountability? What are the most important accountabilities that need to be measured? Do our existing measures get to them, or do we need to develop new measures?

Marty Lustick: In some cases here, we're talking about principles that address behavioral issues, like governance, making it much more difficult to define the right metric.

Les Zendle: Another thing, are we saying that once we put out a measure, we'll have to be willing to say that groups will have to meet a certain threshold to be considered Permanente?

Al Mariani: No physician manager can hope to have an accurate sense of how well things are working without measurement. Every day there are tens of thousands of patient interactions. There definitely should be standards for measuring patient service, quality of care, peer-to-peer service, and medical-legal trends at a minimum. It is the responsibility of the Permanente Medical Groups management to measure these and possibly other parameters of good care and then act on deficiencies. One could debate whether standardized measures are required

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"For our purpose, we really ought to try to focus much more on actual outcomes wherever we can."
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as long as there is measurement and action based upon these measurements.

Andy Wiesenthal: There's a danger that all that gets measured is the existence within a medical group of proper policies and procedures and that in fact there may be no execution. So where's the beef? We have to focus on policies and procedures for compliance assessment. For our purpose, we really ought to try to focus much more on actual outcomes wherever we can. And maybe we don't ask people to meet a threshold initially but rather to provide evidence that the standard is part of their Medical Group's culture and the activities they're engaged in.

Don Parsons: But don't we currently have a limited menu we can use today? We could ask whether the group is MDQR- or JCAHO-accredited? Are they a prepaid group practice? Do physicians make the clinical decisions? Do they have a board of directors? These are some of the criteria that would determine whether a group is Permanente.

Andy Wiesenthal: I would argue that right now, people will push back and make a really cogent argument that there's too much change going on to take on new metrics. And we need to recognize that there are differences between regions of the country and allow some slack for that. At the same time, we can let groups know what the endpoint is and what the expectations are once things stabilize for them.

David Shearn: Menuing is another way of dealing with this. Give Medical Groups 12 measurements,

and ask them to pick, say, six based on their own strategies and local needs. Set a target date for achieving those initial measures, and then ask the group to move on to others.

Marty Lustick: Does MDQR look at elements like our group ethic and similar issues as they conduct their work? Do they evaluate groups against what it means to be Permanente?

Genie Komives: No, they don't. My thought is as we define the Permanente Medicine principles or values, we'd clearly want to include measures that differ from MDQR's. But if we look at the specific measurements within MDQR, are we supposed to come to an agreement or recommendation about establishing a bar and whether that should be regional or national?

Andy Wiesenthal: It sounds clear that we're going to set a national bar. But there are questions about how that's going to play out, over what timeframe, and how aggressive it's going to be. Will we start locally and move toward national standards? If we're going to set a bar, it should be a national bar eventually. It doesn't have to be there tomorrow or even next year. But the goal is to be able to tell patients that they will get the same high-quality care wherever they go. If we can guarantee that, I think we have something to distinguish ourselves, because nobody else can guarantee that.

Les Zendle: We want to identify things that are going to demonstrate our ability to deliver high-quality health care in every Permanente Medical Group. For example, it means that every Medical Group goes through a performance review every year, or MDQR, that the group sets strategic goals that are based not only on what's going on in their community but nationally, as well as on best practices around the Program. When the group falls short of where they want to be, they put resources toward improving in those shortfall areas. This should happen over a reasonable timeframe.

Don Parsons: There's a widespread perception, at least in the external audiences that I talk to, that if you're not measuring something, you're not managing it. One of the things that I think is important about Permanente Medicine is our ability to demonstrate quality to those employers who are asking for it. We have to take that very seriously. Even though it's attractive to score very high on the obvious HEDIS measures, and let it go at that, it's very important for us as physicians to try to keep that quality spectrum broad.



Participants of the Permanente roundtable; from left to right: Les Zendle, MD; Paul Wallace, MD; Lee Jacobs, MD; Marty Lustick, MD; Jed Weissberg, MD; Walid Sidani, MD; Al Mariani, MD; David Shearn, MD; and Andy Wiesenthal, MD.



Walid Sidani: I am hoping that Permanente will set some specific performance targets and specific measures. If we decide that certain outcomes are important, and we agree on the measures for them, there is no reason why they cannot be integrated into MDQR. MDQR can then become the organization that determines or certifies Permanente Medicine.

Paul Wallace: This struggle with measurement is so familiar. There's this dilemma about even figuring out what we want to measure. Then we need to determine whether a metric is associated with it that reflects an outcome or a process. And then there's the targeting and the surrogate if you really can't get at it. And then at some point, you have to loop back around and determine whether it's an important measure. What we probably need to do is just figure how far we can push it and foster an improvement environment. It has to be a long-term strategy with some sort of launch.

Genie Komives: I think looking at ways to ensure that the Medical Group is truly accountable to these principles is important. I think looking at incentives and compensation—the payment structure and how that's implemented—is a valid activity.

Les Zendle: It sounds like we want to measure some areas that we feel are important but are unsure of how to measure them. Then we've got things that we know how to measure, and the reality is we're not sure how important they are. I'm afraid we could focus on areas that we are able to measure and potentially miss those that are really important—the things that are going to allow us to identify real performance problems. That is not the way to get physicians and professionals to improve quality.

Jed Weissberg: I think we've done a really good job of defining a lot of the problems about how to measure Permanente Medicine, even though there are so many dimensions to it. I do not think we have closure on very many questions, but we've had a chance to identify the critical issues. Now we need to continue to take these issues to the frontlines, where the final work of defining Permanente Medicine is going to happen. ❖

The Roundtable transcript was edited by Jon Stewart, TPJ Communications Editor, and Randa Ghnaim, Communications Consultant, Program Offices.

*"Now we need to continue to take these issues to the frontlines, where the final work of defining Permanente Medicine is going to happen."
– Jed Weissberg*

Key Physician Roles

"Physicians will play eight key roles in the future: clinical data collector, shaman, health advisor and wellness coach, knowledge navigator, proceduralist, diagnostician, physician manager, and quality assurance specialist."

*Ian Morrison, PhD,
"The Future of Physicians' Time,"
Annals of Internal Medicine,
January, 2000. 132:1.*



The Permanente Medicine Map

health systems

Early in the effort to better clarify and articulate the basic principles of Permanente Medicine, everyone involved in the project sensed that the real value of the work was being missed or undermined by the form in which the work was presented—the usual PowerPoint discussion document, in this case running to more than 50 pages of often obtuse, highly abstract language. We all felt a need to get our arms around the concept as a unified whole rather than as a series of discrete principles. We wanted to “see” how all the pieces related to one another and to the historical, professional, and industry environment that helped shape them. Hence, the Permanente Medicine Map.

The map grew out of a series of discussions and focus groups led by Tomi Nagai-Rothe, a graphic artist/facilitator from Grove Consultants, International, of San Francisco. Her firm virtually invented the technique of graphically mapping complex corporate mission and strategy statements to enhance the clarity of strategic thinking and communication. As the map developed, various versions of the 4' by 8' graphic were mounted on conference room walls to stimulate work group discussion.

This, then, is the story of Permanente Medicine, the conceptual vehicle (or fleet, in this case) that we depend upon to carry us to a sustainable future.

The Permanente Story, So Far. . . .

The Permanente Fleet, representing all the PMGs and manned by physicians, employees, and Health Plan members, sets out upon a hazardous sea in search of the distant shores of the KP Promise, which represents success and sustainability. The Fleet, pushed along by the powerful winds of the group ethic, sails forth from distant historical streams that carried Permanente through the con-

struction of the L.A. aqueduct in the Mojave Desert, the Grand Coulee Dam in the 1930s, the Kaiser shipyards of WW II, and past Lake Tahoe, where the fundamental Kaiser Permanente partnership was hammered out in the Tahoe Agreement in 1955.

Already, the Fleet has encountered the rough seas of the financial crisis of 1997-98, and some medical groups have drifted into the dangerous doldrums of inconsistent performance. Meanwhile, fee-for-service is vanishing beneath the waves, while some competitors are being swept up in a vicious whirlpool of industry consolidation and merger. Ahead lie the hazard-strewn narrow straits and rocky shoals of government regulation, rising medical costs, the temptations of for-profit conversion, and the punishing storms of the managed care backlash. Pharmaceutical sharks lurk in the narrows.

Fortunately, the Permanente Fleet is navigating itself into the Current of Evidence-Based Medicine, which leads through the hazards and into the Sea of Superior Care that will be made possible by new information technology acquired at Silicon Island. What's more, the Fleet is superbly equipped with the latest navigation technology and with a superstructure of time-tested, ethics-based principles. As illustrated in the cutout in the bottom right corner, the sturdy sails of self-governance, self-management, and group responsibility power each ship of the fleet. And the Labor-Management Partnership is there to hoist the dead weight of labor conflicts that have held us back in the past. In the cutout on the left, the three performance principles of quality medicine, the Permanente-patient relationship, and wise resource management help each ship steer a safe course, aided by the latest in navigational tools, including the Care Management Institute's clinical guidelines and a robust set of performance measures. ❖

