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Statement for the Record

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Kaiser Permanente

Defense Health Care Reform

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Subcommittee Chairman Graham, Ranking Member Gillibrand, and Members of the Committee, thank you for the invitation to testify today. I am Dr. Bernadette Loftus, Executive-in-Charge of the Mid-Atlantic Permanente Medical Group at Kaiser Permanente. As you continue your efforts to build and maintain a top performing health care delivery system for the women and men of our armed services and their families, Kaiser Permanente is pleased to support you and the leaders of the Military Health System.

**Introduction and Background**

Kaiser Permanente is the largest private integrated healthcare delivery system in the U.S., with 10.3 million members in eight states and the District of Columbia. We are committed to providing high-quality, affordable health care services and improving the health of our members and the communities we serve. Our roots date back to 1945. Our model was born out of the innovation and ingenuity that mobilized our nation for World War II when Henry J. Kaiser and Dr. Sidney Garfield teamed up to provide medical care for tens of thousands of workers building ships around the clock for the war effort.

Today, Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 38 hospitals and over 600 other clinical facilities; and the Permanente Medical Groups, which are multi-specialty group practices employing over 18,000 physicians that contract with Kaiser Foundation Health Plan to provide or arrange health care services for Kaiser Permanente's members. Kaiser Permanente operates in California, Hawaii, Oregon, Washington, Colorado, Georgia, Maryland, Virginia and the District of Columbia. Many of our service areas include a significant presence of military personnel and families.

Kaiser Permanente is honored and grateful to have many former career military and military-trained physicians, nurses, and other clinicians working in our system, including some who remain active in the reserves. The training and practice environment of the Military Health System, as well as the values and mission-driven spirit of the women and men who join the Military Health System, produce clinicians who succeed in, and help lead our system. We also appreciate the ongoing opportunities our clinical and operational leaders have to collaborate with leaders in the Military Health System to share best practices and learn from one another.

**Aligning Incentives for High-Performing Integrated Health Care Delivery**

Kaiser Permanente's integrated model of care is based on prepayment rather than the volume-driven, fee-for-service reimbursement that dominates U.S. health care. Our integrated delivery system is also characterized by the direct operation of state-of-the art inpatient and outpatient facilities, pharmacies, and diagnostic and laboratory services. Care is delivered primarily by our contracted multi-specialty physician groups and clinical staff employed by our physician groups, hospitals, and health plans in each of our regions.

By combining care and coverage in an integrated system, our physicians are able to prioritize prevention and population health, while also delivering high quality complex and acute care. Kaiser Foundation Hospitals and Health Plan's not-for-profit governance structure means our financial margins are reinvested in care infrastructure and care transformation, health information technology, research, workforce training, and the support of community health and community benefit.

Our advanced electronic medical record, called KPHealthConnect®, allows our clinicians to collaborate in teams, share information securely, and reduce duplicative testing. It also provides longitudinal tracking of our members' health, and supports our robust quality improvement programs. The member-facing component of our electronic health record, My Health Manager, allows members to exchange secure email with their care team, schedule appointments, get test results, and request prescription refills online. These features are also incorporated in our mobile "app" to provide more ways for our members to connect with us and manage health needs. In 2014, Kaiser Permanente members sent more than 20 million secure emails to their providers.

**Delivering High-Quality Care**

Kaiser Permanente is a high performing health system as recognized by the Commonwealth Fund and the National Committee for Quality Assurance (NCQA). In 2015, only two systems in the entire U.S. received a "perfect" 5 out of 5 rating from NCQA for both commercial and Medicare patients, and they were Kaiser Permanente of the Mid-Atlantic States, and Kaiser Permanente of Northern California. In fact, no Kaiser Permanente plan received lower than a 4.5 out of 5 rating in 2015, a performance level that only 10% of all plans nationwide achieved.

At Kaiser Permanente, we believe that achievement of excellent outcomes is based on understanding and relentlessly measuring current performance, so that opportunities for improvement are continuously identified. We strategically exploit the full benefits of a uniform system-wide electronic health record, which we use to create systems of care that make it easy to do the right thing, and hard to do the wrong. This is accompanied by crystal-clear expectation around behavioral norms and performance of our physicians and staff.

**A Commitment to Measuring Quality and Access**

No health care delivery system can reliably achieve better results unless it knows its current results. At Kaiser Permanente, we measure all aspects of our care delivery at an individual, local, regional, and national level. We choose measures that are evidence-based, nationally-recognized, and reasonably comparable across geographies and populations. This is to minimize the distracting argument that goes like this: "my patients are unique, therefore I cannot be held accountable to achieve any particular measurement or outcome." In recognition that some patients are sicker than others, we do employ standard risk-adjustment methodologies where appropriate, primarily with inpatient quality measures. As a result of our measurement philosophy, we spend a lot of time on HEDIS measures,[1] Consumer Assessment of Health Plans and Systems (CAHPS)[2] satisfaction measures, and their inpatient twin, HCAHPS (both developed by the Agency for Healthcare Research and Quality), and The Joint Commission

[1] http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx
[2] https://cahps.ahrq.gov/

core and ORYX measures.[3] We feel confident that we can fairly assess performance, down to the individual practitioner level, across diverse populations using these measures.

We also assiduously measure access to care, because there is no quality of care unless there is first access to care. We have learned from over two decades of studying the correlation between patient satisfaction and our objective speed-to-access in days, that patients have a much higher speed-to-access in days than physicians generally feel is medically necessary. Because of this, we set our internal access standards based on our members' expectations. Our best levels of patient satisfaction with routine specialty access, for example, correlate with a speed-to-access of less than ten calendar days from date of referral. We measure and report access in primary care on a daily basis. The expectation for physician managers is that the supply of appointments in primary care will be managed dynamically on a daily basis to adjust to the ebb and flow of demand. We measure and report specialty access weekly, and expect responsible managers to take action to augment appointment supply when our predictive models indicate the likelihood that access will not meet our standards.

The science of excellent access is just that, a science, although it is a relatively simple one. The supply of available appointments must always exceed historical demand for appointments, in order to ensure great access, and so our physician managers are trained and retrained on the constant management that must be brought to bear to maintain access.

Advances in technology enable us to augment face-to-face appointment access with secure email communications between patients and their physicians, and now video visits. Our prepaid model allows us to adopt these technologies to create capacity for expanded access using the most clinically appropriate, convenient options for our patients. We currently offer video visits through our clinical advice call centers, which operate 24 hours a day, and we are rolling out the option of telehealth visits in primary care and many specialties across our regions. As a data-driven system, we are collecting data and evaluating patient outcomes as we expand these virtual services. Early results show our members value these new modalities of care.

High achievement in quality requires the same degree of performance measurement, analytics, and reporting. Specific to quality management, we produce monthly "variation" reports, which display, with clear graphics, the variation in performance on key quality metrics between departments on those same measures. These unblinded reports allow us to identify the high and low individual performers in similarly situated practices, and this creates the opportunity for dialogue around improvement. Data transparency spurs not only dialogue, but a little competition as well, which in turn engenders more rapid improvement. Data literally is delivered to every physician's desktop. Our physicians are able to check their own performance on quality measures against those of others in their department on a daily basis.

**Emphasizing Prevention and Managing Chronic Conditions**

At Kaiser Permanente, prevention and quality is everyone's responsibility. We do not leave it up to our primary care physicians alone. It is our cultural expectation that every physician, regardless of specialty, will address the prevention and chronic disease measures for every patient she sees. This means that

[3] http://www.jointcommission.org/accreditation/performance_measurementoryx.aspx

dermatologists and orthopedic surgeons are as responsible for ensuring that each patient with diabetes gets his HgbA1c measured at the appropriate interval, or that a woman gets her screening mammogram that may be due, as are those patients' primary care physicians. We continually collect and analyze data about our patients' health status, and lab, imaging, and other test results, and use that information to create extensive population health registries. These registries inform decision support software in our electronic health record. As a result, every physician—primary care or specialist—is alerted at every visit to every patient who is due or overdue for prevention or treatment measures.

Patients with chronic conditions (i.e. diabetes, asthma, congestive heart failure, and hypertension) often require the most resources. By stratifying patients according to diagnosis and need, effective disease management programs are seamlessly integrated into our care models, with features that include dedicated case managers, teams that include nurses, social workers, dieticians, and pharmacists, and clinical practice guidelines and decision-support tools. By making the right thing easy to do, our goal is to provide care that is safe, reliable, effective, and equitable.

**Conclusion**

Once again, thank you for inviting me to testify before the Senate Armed Services Committee today on behalf of Kaiser Permanente. I hope that the information provided will be useful to you as you consider possible changes to the Military Health System and the Tricare program. Kaiser Permanente would be honored to provide further assistance to you in the future, and to serve the men and women of the U.S. Military and their families in any way we can.