

Chapter Four

LEARNING FROM A LONGSTANDING FOCUS ON ACCOUNTABLE CARE TO IMPROVE CARE FOR EVERYONE

One of the very best ways of reducing care disparities in America is to improve care for everyone. A rising tide of continuously improving, better care will bring care for all groups to a consistently higher level. That actually should be possible to do. It may, in fact, be the only way we can eliminate some disparities that exist today in care delivery. That is true because we can't focus on improving care for just a subset of our population in a functionality vacuum. The same tools that can be used to reduce disparities are the same tools we need to use to improve care for everyone. We need to put the tools and processes in place to improve care for everyone, and then we will have those tools in place to fix disparities and to eliminate the gaps we now have in care delivery and care outcomes.

That work is possible to do. This is very much the right time to do that work. As noted in the prior chapter, the health care policy agenda in this country is increasingly focused on creating various kinds of team care, data-supported care, and accountable care for all Americans. Those areas of focus on improved care functionality will each be very useful in reducing care disparities. Medicare, Medicaid, and private payers are all trying to figure out how to create and support care delivery approaches that will improve overall care by making care both better and more affordable.

As noted earlier -- it costs less to prevent an asthma crisis than it does to treat an asthma crisis. The government-funded portion of that care improvement agenda will be particularly important for the key populations where significant care disparities exist today. Those tools are needed even more for the patients whose care is less than adequate today. The people who are advocates for computer-supported care, patient-focused team care, and the use of process improvement techniques to enhance care delivery tend to believe that care will get better for all patients with the right focus, the right business model, and the right tool kit.

People who look closely at the issues of care disparities that were outlined earlier in this book also tend to share the belief that we need better data-gathering as a nation, and we need better care support tools for all caregivers and for all patients if we want to successfully address and remedy the care disparity issues that exist today, in the most focused and effective ways. The perceived need for those tools is well-founded. Those are the tools we need to do that work. As noted earlier, both of those beliefs and those tools are being tested today in an operational way in the Kaiser Permanente care settings.

The theory that says one of the best ways to reduce care disparities is to make care better for all patients is happening today for the 9 million extremely diverse patients and the even

more diverse care teams at Kaiser Permanente. Data shown earlier in this book looks at care improvement at Kaiser Permanente overall and by race and ethnicity. That overall data and that group-specific data should be encouraging for the rest of the country. Those improvements in performance inside the Kaiser Permanente infrastructure of care delivery clearly represent the kind of gap-reduction successes that strong advocates of disparity improvement and gap closures would like to see happen for the whole country.

As noted earlier, this is a particularly good time to learn from that work at Kaiser Permanente because the new medical homes and the new ACOs that are forming in multiple settings all need to create a functional tool kit so that caregivers in those settings can build in several ways on the tool kits that are already in place at Kaiser Permanente.

What can the new ACOs and medical homes learn from those existing Kaiser Permanente tool kits?

Kaiser Permanente Is a Functioning ACO Now

The first point for those new care organizations to understand is that Kaiser Permanente is functionally an accountable care organization now. Kaiser Permanente is a prototype ACO. Kaiser Permanente sells packages of care now and does not use a piecework payment model today for its cash flow. As noted earlier in this book, other health care businesses in this country almost all bill separately for each piece of care. Kaiser Permanente has a total per-patient cash flow as its business model and actually has no internal bills for any elements of care. Each Kaiser Permanente member today buys a package of care. They buy that package by paying a monthly premium. The monthly premium is a flat amount paid per member, per month. That premium can be paid by the member, by the employer, by the government, or by various combinations of those payers.

The key to understand is that the basic cash flow model for Kaiser Permanente is to sell a full package of care for a monthly price. That cash flow from each member goes to Kaiser Permanente as a monthly payment package, and that money is then functionally used as needed to deliver both the care and the prevention services that Kaiser Permanente members and patients need.

It is true from a cash flow perspective that some patients at Kaiser Permanente have chosen to buy deductible benefit plans. Some people bought those plans from Kaiser Permanente to reduce their premium levels -- and those people with deductible plans do pay individual prices for the pieces of care that are needed after they meet their personal deductible amount. But the economic reality is that the cash flow from those payments for pieces of care from those patients represents a very small portion of the Kaiser Permanente total revenue. Those

payments do not change the basic business model for care. Inside Kaiser Permanente, there are hospital budgets, but there are no internal hospital prices.

All of the Permanente doctors receive a salary. Permanente physicians are not paid based on an accumulation of fees that are created by individual pieces of care that each doctor delivers. Fees are not an internal cash flow reality, and fees are not linked to any doctor's individual cash flow at Kaiser Permanente. That means that the Permanente doctors can focus on delivering needed care for patients without being affected financially by any of their care decisions. Salaries are the physician compensation approach. Salaries create a very different care context for caregivers than piecework payment approaches.

The Mayo Clinic, the Cleveland Clinic, and the Geisinger Clinic also all use salaries instead of fees as the way they pay their physicians. Salaries are a very liberating way for caregivers in those care settings to be paid because the take-home pay of any physician can't be adversely affected by doing or not doing unneeded but profitable individual care procedures.

Many of the people who are designing the new ACOs in care sites across the country are working to design cash flow models that move away from piecework payments to package-based purchases of care.

The new ACOs tend to understand the obvious advantages of selling packages of care, and most of the new ACOs are attempting to create cash flow approaches that more closely resemble and parallel the macro cash flow approach that exist at Kaiser Permanente. That is a good direction for those ACOs to follow.

Making Care Safer and Better Becomes a Good Business Decision

That is a very good strategy for those care sites to follow.

Receiving a prepayment amount every month for each patient changes the overall business model of health care organizations. There are a number of significant benefits for health care organizations and care delivery that result from not being paid for care by the piece. Making care better and safer for the patient becomes a wise business decision instead of creating a revenue loss for the caregivers when the care teams can function in a prepaid, package-based care setting.

The Kaiser Permanente Package Payment Hospitals Have -- for Example -- Fewer Hospital-Acquired Pressure Ulcers

Kaiser Permanente hospitals have incredibly low levels of hospital-acquired pressure ulcers, for example.¹⁴¹ In the rest of the country, on average, 7 to 15 percent of all patients end up with those painful, disfiguring and sometimes fatal ulcers.¹⁴² The number of those unfortunate pressure ulcers tends to be higher in some of the hospitals serving minority patients. The standard business model of care responds in a very perverse way to the cash flow relating to those ulcers. Those hospitals that get paid for all care by the piece generally receive paid additional fees for those patients that are based on the additional care needs that are created by those ulcers. That payment for those damaged patients can create a lot of revenue. On average, more than 7 percent of patients get those ulcers. Some hospitals have over 10 percent of their patients with those ulcers.¹⁴³

In the Kaiser Permanente-owned hospitals, however, where care is sold by the package and not by the piece -- the average level of pressure ulcers is now under 1 percent of all patients.¹⁴⁴ One percent is a very low number. Several Kaiser Permanente hospitals have not had one single stage 2 or higher pressure ulcer for more than a year.¹⁴⁵ That is far better care for those patients.

So the reality is -- for that very common patient-damaging infection -- the very highly diverse caregivers at Kaiser Permanente deliver spectacular, incredibly focused, very highly skilled care for the hugely diverse Kaiser Permanente patient population to keep those ulcers from happening. That level of care success isn't accidental or easy. The care levels and the patient-focused care commitment required by the hospital-based care teams to achieve that high level of care quality are intense. As a result, the success levels for pressure ulcers in those hospitals may be the best in the world. The cash flow for those ulcers that occur at Kaiser Permanente works like a well-designed ACO cash flow should work. There is an increase in care quality and there is no decrease in care revenue at Kaiser Permanente when the number of pressure ulcers has been hugely reduced. In other piecework-reimbursed care settings, that much safer and much better level of care for those patients could actually create a significant revenue loss for the piecework paid care sites.

That is an important example to keep in mind as the country considers expanding the use of both ACOs and medical homes and applying them to programs that serve our minority populations. Safety in those care settings can be enhanced by not financially rewarding the consequences of unsafe care and by actually rewarding the consequences of safe care.

Being Paid by the Piece Has Several Negative, Dysfunctional, and Perverse Consequences

Being paid by the piece has a number of very perverse and completely unintended consequences. Care volume is one problem. That is the most widely known problem with piecework payment approaches. Most economists who look at health care issues understand the sheer care volume incentives that inherently result for any vendor for any product when the vendor is being paid entirely by the piece. The fact that we have more CT scans done in this country than any other country in the world other than Japan is obviously based at least in part on the usually highly profitable fees that are paid to each scan owner when each scan is done.

There are many other comparable examples of care volumes and patterns of care that are based more on caregiver revenue opportunities than patient care needs. Cesarean-sections are a good example. C-sections are often pointed to as an area where the volume incentives inherent in a piecework payment model that pays much more money for a C-section compared to the payment for a normal delivery creates perverse, unfortunate, and medically inappropriate care volumes. The relationship between piecework payment incentives and the care unit volume for multiple areas of care is well-understood by most health care economists.

Piecework Payment Cripples Care Improvement

That volume-trigger and incentive is not, however, the biggest economic flaw in that particular payment model. The biggest flaw in the piecework model is the fact that being paid by the piece cripples, penalizes, stifles, and stands as a direct barrier against most care improvement agendas and processes. Continuous improvement processes are very rare in American health care. That lack of process improvement is true primarily because the piecework payment model we use to buy care today generally prevents caregivers who improve care from realizing any benefit for their care site or their care business unit when care improvements are performed. The piecework payment model we use to buy care actually almost always penalizes caregivers for making care better or more efficient. That is a highly perverse impact. It needs to be understood. That real-world impact of that payment model seriously inhibits continuous improvement use in care delivery. Care sites do not do the work that is needed to eliminate duplicate tests for any given patient when each and every test generates a fee and when eliminating the test eliminates that fee -- with no reward of any kind for the care site that does the reengineering that eliminates the test. No business ever reengineers against its own self-interest. So the piecework payment approach inhibits care process improvement, and it also creates very rigid approaches to care.

Kaiser Permanente, by contrast, is not paid for care by the piece. Fees do not dictate care at Kaiser Permanente. The fact that the Kaiser Permanente care system is liberated from fees has been very useful in putting together the care delivery infrastructure and the entire array of care processes for patients that are much more patient focused instead of being fee-schedule focused.

The standard Medicare, Medicaid, and private insurance fee schedules that determine eligible care in other care settings do not define or limit care at Kaiser Permanente. That is a very different way of looking at care delivery design and opportunities. Those standard insurance fee schedules actually create rigid patterns of care for care sites in this country. Other care systems and care sites that are paid only by the piece usually only do the exact work that is listed on those insurer-approved fee schedules. Those schedules define a limited, rigid, and inflexible list of services.

Asthma patients, for example, can often benefit significantly when a nurse can call the patient to be sure the patient is refilling their prescriptions. The nurses can also coach each patient on effective early intervention approaches. That work by nurses can help reduce the number of asthma crises significantly. That fact has been proven repeatedly in several care settings. That proactive work is not done in most fee-based care settings, however, because having a nurse call a patient to coordinate needed care is not listed on the approved set of billable services for most payers. So instead of having children across the country who have fewer asthma crises, we have far too many children who end up in the emergency room actually going through the misery of a painful and terrifying asthma crisis that could have been prevented with proactive care approaches.

We Get What We Pay For

The irony of that situation, of course, is that each and every one of those emergency care expenses that are needed for those asthma patients who are in a personal care crisis are all listed on the approved fee schedule. The caregivers are paid for that crisis care. Those very expensive sets of crisis response care services happen in great numbers across this country. They generate a lot of revenue. Nurse phone calls to patients to prevent asthma attacks are not on the approved fee schedule, however, so those nurse calls are rare.

The basic truth is pretty simple.

We get what we pay for. As noted earlier, in a well-structured, patient-centered medical home, the homes are paid a lump sum for multiple services. That lump sum cash flow per patient can liberate the care sites from that fee schedule for at least some services. Some level of lump sum payment per patient usually is used in those new team care settings -- and those lump sum payments can fund those kinds of nurse calls and proactive follow-up visits and

contacts with the patients. Those lump sum payments can also fund e-visits between doctors and patients that are usually not reimbursed by the standard insurance fee schedule.

So medical homes and accountable care organizations that sell care as a package will be able to design their care and their information flow around the patient, and not just around the fee schedule. Those ACOs and medical homes can use nurses, electronic care connections, and much more flexible care approaches to meet patient needs.

Fourteen HIV Care Steps Not on a Medicare Fee Schedule

Multiple examples have shown that care can be a lot better when care processes are freed from fee-schedule rigidity.

At Kaiser Permanente, the care delivery strategy and approach that has reduced HIV deaths to less than half of the national average¹⁴⁶ has 14 steps in the most current care process that do not show up on a Medicare, Medicaid, or standard insurance company fee schedule.¹⁴⁷ Those 14 steps are patient-focused, nonbillable, nonfee-schedule activities that help create much better care outcomes for those HIV patients. There is no “CPT” code for those services. If Kaiser Permanente only did the specific HIV treatment steps for those patients that are listed on the approved Medicare fee schedule -- and limited care to that fee schedule list of services -- the death rate for those patients could double. Twice as many people die today in the other care settings in America that are paid only by the piece for that care.

HIV isn't the only example of patient-focused care and better care that can result from the care team not being confined to a fee schedule. Kaiser Permanente has also reduced broken bones for seniors by over a third.¹⁴⁸ That is extremely important, life-saving work. A high percentage of older seniors who break bones die within a year. That work to prevent broken bones can be extremely important work for low income patients who don't have the resources to deal with the long term expenses for themselves and their families that can be created by a broken bone. Preventing those breaks is important work to do. Again -- six of the nine steps that are currently done to reduce the number of broken bones also do not show up on the Medicare or Medicaid fee schedule.¹⁴⁹ Those fee-schedule constraints dictate care in most care settings, and they are a reality we need to understand if we want to improve care.

Those defined fee-schedule approved service lists that are created and administered by Medicare, Medicaid, and by typical insurance companies generally restrict the delivery of care to a fairly rigid set of services. Those lists limit care, and they can badly cripple and even kill continuous improvement processes in American care sites.

Reengineering Processes Rarely Happen in Health Care

Health care is almost alone in not using reengineering tools to improve processes and create efficiencies.

Reengineering processes have made huge improvements in both products and services in other multiple industries. Reengineering, by contrast, is a rare occurrence in health care. It is rare in health care because really well done reengineering processes often simplify whatever approach is being reengineered. As noted earlier, when you simplify anything in a piecework payment model, you run the risk of eliminating a billable piece for the caregiver from the overall care delivery process. Losing a billable piece from the process simply and purely reduces revenue. As noted earlier, no industry ever reengineers against its own self-interest. Health care follows that same path. Also, as noted earlier, even something as simple as eliminating duplicate tests between various care sites that are seeing the exact same patient is unlikely to happen in most care settings simply because each reduction of a duplicate service will reduce the revenue for that duplicating care site by the full payment amount they receive to do that particular service. When a scan can generate a 500- to 1,000-dollar invoice,¹⁵⁰ eliminating a scan to use the exact same test already done for that patient at another site simply reduces the revenue for that scan from the second site.

Again -- if the new ACOs are well-designed, and if they are set up to have a bundled payment of some kind for all needed care, and if the ACO business units are freed by their payers from the tyranny of a rigidly defined piecework cash flow -- then health care reengineering processes could flourish and thrive, and care improvement operational gains as basic as eliminating purely duplicate tests could be significantly encouraged.

Lab Test Results Can Go Directly to Patients With No Reduction in Caregiver Revenue

The number of unnecessary duplicate tests done at Kaiser Permanente today is tiny -- both because there is no additional revenue inside Kaiser Permanente for each test and because Kaiser Permanente has set up a computerized data flow support system that lets each test that is done for each patient be permanently stored in an electronic form and instantly available to every relevant caregiver who needs it in real time.

Likewise, a lab test result that is done at Kaiser Permanente goes directly from the laboratory to the medical record and also goes to the doctor who ordered the test. Processes for data flow relative to lab test results are much improved. It used to sometimes take days to get basic information from the lab to the caregivers and then to the patient. That work is now

done in real time -- with the test results now ideally going to the caregiver instantly as each test is completed. For most basic outpatient tests at Kaiser Permanente, the lab results are usually also sent directly to the patient at the same time those lab results go to the physician. Kaiser Permanente patients received over 30 million lab results directly and on their personal computers and their smartphones last year.¹⁵¹

The payment model of being paid for an entire package of care made that whole, very convenient information flow to patients easy to do.

Why does being paid by the package instead of being paid by the piece make that type of direct information flow about lab tests more likely to happen?

Cash flow is the answer.

In standard fee-based care settings, the primary care doctors can usually bill for an additional office visit when the patients return to the doctor's office to get their lab tests. Those fees charged to the patients for those visits can run from 100 to 200 or more dollars per visit. When each of the patients who had the lab tests done comes back to the clinic and to the doctor's office to receive their lab results in person, that can generate a significant amount of cash for the care site.

At Kaiser Permanente, the lab results are still given to the patient in person by the doctor when there is a medical need for the visit with the doctor, but those visits with the doctor are not scheduled just to generate a bill for the care site. Most lab results go to the patient -- with a clear explanation of their significance -- and the patients do not need to return to the clinic to get the results in-person and onsite.

Being paid by the package and not by the piece clearly creates a whole range of care options and care delivery approaches that do not exist when insurance companies define each of the pieces of care that will generate a payment and keep those lists very rigid over time. Nearly a third of the care and care support resources that are used today inside Kaiser Permanente medical sites to support patient care are spent on services that would not trigger a Medicare, or Medicaid, or standard insurance company fee payment if Kaiser Permanente were to bill one of those payers for those services.

Kaiser Permanente has now invested billions of dollars in computerizing all aspects of the care data flow.¹⁵² Kaiser Permanente did that work without worrying about whether or not any piece of care that would be supported by the new care systems would be billable. Everything relating to care data is now electronic. Imaging is done digitally. The entire medical record is electronic. Care reminders and care prompts are done electronically for both caregivers and patients.

One internal Kaiser Permanente care support system -- The Outpatient Safety Net -- is a highly complex computer program that scans the files looking for gaps in the fabric of needed

care for Kaiser Permanente patients. That safety net data screening identifies specific care needs -- like needed but current follow-up visits for early-detection aneurysm patients. Or looking to see if patients who need some level of chronic care medication have, in fact, done their needed basic prescription refills.

Those care support systems have improved care.

The growing amount of number-one quality and number-one safety scores in the country on multiple care quality and care functionality issues that have been achieved by Kaiser Permanente caregivers isn't accidental or coincidental. It is entirely intentional. Computer support systems help both patients and care teams remember the right next steps for care, and then those systems help track whether or not those care steps were achieved. The extremely high level of blood pressure control that was mentioned in Chapter Two isn't accidental; nor is the high level of colon cancer detection. Overall, use of the new electronic care support tools is a learning process. Those systems are continuously improving. Flexible process design happens. Those care improvement steps are all being done without worrying about whether or not each and every piece of work will trigger a payment from an authorized fee schedule. There is no fee for tracking to see if newly diagnosed patients are filing their prescription, and there is no fee for running computer scans or to see if patients are doing follow-up care. There is no fee for coaching HIV patients on persistent medication compliance. But lives are saved -- and money is saved -- because those processes exist and do what they are intended to do.

Six Guidelines That Can Help Anchor Accountable Care

So Kaiser Permanente is already a model for accountable care. ACOs that are figuring out how to succeed in the new care delivery approach and cash flow model can and should look to Kaiser Permanente for some approaches that work well to meet those goals.

Those newly forming ACOs might find it useful to know that the basic accountable care process at Kaiser Permanente has made extensive use of six key guidelines. The six key guidelines should be extremely relevant and useful to anyone who is trying to improve overall care in an organizational setting. Those guidelines are of particular value to anyone who is trying to reduce the disparities in care that exist today between various ethnic and racial groups, because each of those guidelines tees up approaches and tools that can directly help reduce care disparities. The use of those guidelines has helped reduce care disparities at Kaiser Permanente.

The six key guidelines are:

- 1) All, All, All
- 2) Make the right thing easy to do
- 3) Continuously improve

- 4) Focus on the patient
- 5) Create available and transparent data
- 6) Be Us -- Eliminate Disparities

Many of the new care systems that are being established in other care settings could benefit significantly by using some or all of those same six guidelines for both planning and operations.

Those six guidelines are worth understanding because they did not happen in a vacuum. They did not come into being through theoretical, academic, externally created research. They are all working, functional guidelines that steer operational thinking and care improvement, and they all evolved through and with the care improvement agenda in place at Kaiser Permanente.

The first guideline is very basic. Guideline one is to have all of the information about each patient.

1) All/All/All

All, All, All is a very basic and foundational systems development guideline that all of America could and should follow as the new care systems are being created. All, All, All means all of the data about all of the patients all of the time. All of the key Kaiser Permanente systems, processes, and data flows have been built around that guideline, building on a patient-focused, patient-centered, and inclusive database for each patient -- with the functional and operational goal of all of those processes aimed at having each patient's data available in real time to the caregiver at the point of care.

If you understood care delivery, that guideline seems logical -- even simplistic. But the truth is that far too many other care settings today actually build their data infrastructure around their billing processes or around their actual physical care sites, rather than building their overall data planning and data flow around patients. Having site-specific data isn't entirely wrong. Having care-site relevant data can be a good thing -- but site-limited data is woefully and painfully inadequate as an overall data strategy. If caregivers only have patient data stored by site, then the data for each patient will be in splinters that are separated, segregated, and inadequate for care support. Data files that are defined and set up only by each of the patients' care sites is a really inadequate and dysfunctional way to design the data flows for care. The best way to design data storage and data linkages is to design the macro system to create electronic data about the care pieces for each patient so the computerized information from each element and site of care delivery constantly updates each patient's individual data file.

That all/all/all model works. That data organization creates a great tool. Care is better. The stroke death rate at Kaiser Permanente is down 40 percent in just a few years¹⁵³ because that

full set of data exists for each patient and because the available care data is skillfully used by the care team and the caregivers.

This is a very good time for people in the care delivery world to think about that guideline.

Just about everyone in health care who isn't computerized now is planning to become computerized. Not everyone is planning to do their computerization in a way that creates a data focus that is built on each patient. Many sites who have already implemented electronic records only computerized their own site-specific data, and those care sites can't link their own data to other caregivers who are caring for the same patients. As noted earlier, that is a deeply inferior and badly flawed data model. That splintering isn't necessary, and it is highly dysfunctional.

So the advice point on that issue is this -- the rest of health care should not be setting up data projects or data use approaches that do not result in all/all/all data sharing for each patient. All/all/all works, and it should be the core of the system design and implementation efforts that are being done across all care sites -- particularly the ones who want to succeed as ACOs or function as medical homes. That work is very much needed if we want to reduce care delivery disparities and close care gaps in America.

2) Make the Right Thing Easy to Do

The second piece of advice is -- make the right thing easy to do.

Making the right thing easy to do is another very basic care mantra used at Kaiser Permanente that can and should be used by accountable care organizations and patient-centered medical homes across the country.

In the management of complex organizations, it can be very useful to have some basic underlying guidelines that function as the underpinnings of both strategic and operational thinking. "Make the Right Thing Easy to Do" is a basic guideline that serves that purpose for a wide range of issues at Kaiser Permanente. That guideline is used as a compass and a guidepost for figuring out how to deal with an entire array of functional situations -- including systems design, process development, and care infrastructure use.

The guideline has two key and highly important parts. The first part is to figure out the "right thing" to do for any given situation. The second part is to figure out how to make that "right thing" easy to do. When that two-part process is done well, it is immensely powerful and highly effective. Having all patient data available for caregivers is obviously a right thing to do, for example. The challenge for the systems people who follow that overall guidance is to figure out how to make access to that data easy to do. Likewise, having the best medical science available to caregivers is obviously a "right thing" to do. For most of the caregivers in the world, having

consistent access to best medical science is not only not easy to do -- it is often impossible to do. Literally impossible. Medical science changes all the time. There are more than 80,000 medical journal articles published every year.¹⁵⁴ No individual doctor on the planet can read all of the relevant journals and still have time to see patients.

The Institute of Medicine (IOM) has recognized that for many care delivery situations, the current care practices and approaches of the caregivers are not based on the best available information.¹⁵⁵ The IOM now has a taskforce set up whose goal is to have 90 percent of the care delivered in this country based on best medical science by 2020.¹⁵⁶ The level of evidence-based care being done in this country is well below that 90-percent goal today.¹⁵⁷

Kaiser Permanente recognized that the problem of making sure all caregivers have access to current and relevant medical information does exist. Kaiser Permanente believes that having access to that key information for every caregiver is very much "The Right Thing to Do."

So the challenge was -- how can that need to have access to medical science and to information about best care become easy to do for the caregivers of Kaiser Permanente?

How did Kaiser Permanente make scientific data access for caregivers easy to do?

The answer is elegant and simple.

Kaiser Permanente created an electronic medical library. The library is easily accessible. The library has in it all of the basic medical textbooks, hundreds of thousands of journal articles, and more than 2,500 best practice care protocols.¹⁵⁸ The care protocols are based on the best thinking of expert teams of caregivers who have looked systematically at the best medical science. The electronic medical library is available 24 hours a day, 7 days a week for all Kaiser Permanente caregivers. The library is even accessible by caregivers remotely using their smartphones or computers.

It is possible that no other major care team in the world has access to current medical science that is as complete, useful, and entirely functional as the data that is available today to the Kaiser Permanente care team. The electronic library has gone through several major enhancements that make it continuously easier to use. A standing committee of caregivers works on improving the system. An entire team of caregivers continuously refreshes the content and the science in the library. The research in the library is current because a dedicated, full-time team of medical experts reads through the research developed elsewhere in the world to find the nuggets and the key learnings that can be used to enhance the quality of care delivery at Kaiser Permanente.

Having access to the best medical science is the right thing to do. Embedding that science in an electronic library makes that right thing easy to do. The electronic library currently gets used roughly 1 million times every month by the care team.¹⁵⁹

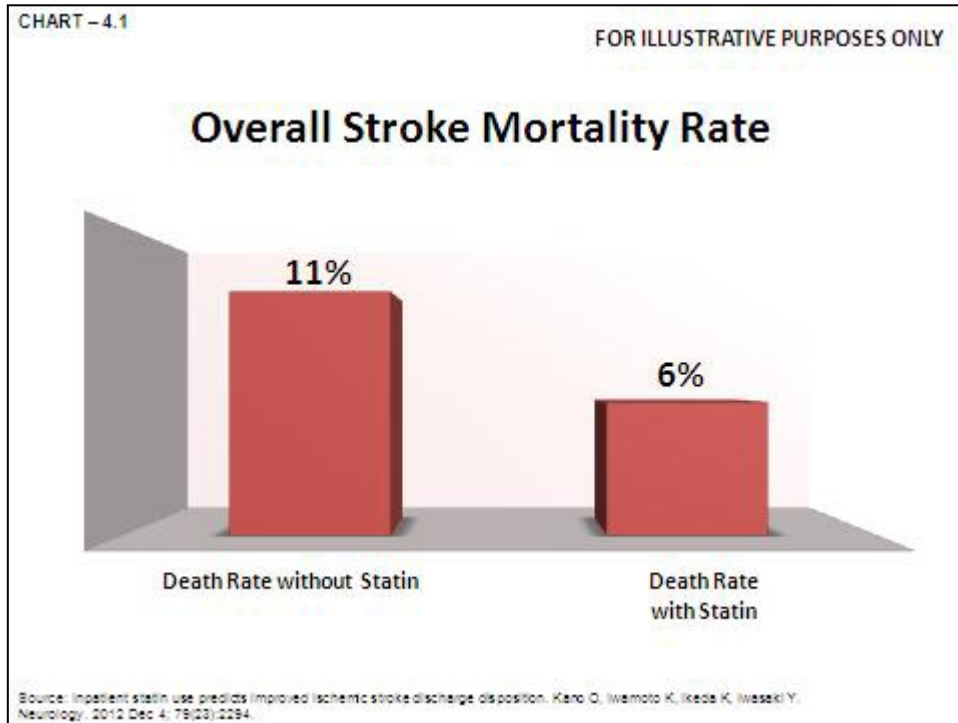
Other caregivers in this country need that same model. All of the organizations who are creating ACOs should be working on building or buying their own access to a functioning electronic medical library. Care consistency and best care are hard to do without electronic medical library tools of one kind or another.

Major Differences Existed In the Death Rate for Stroke Patients

That entire “make the right thing easy to do” process also works well for stroke patient care. The stroke care improvement process was triggered in part by important research that was done on stroke deaths that happened inside Kaiser Permanente hospitals. Kaiser Permanente does a lot of research. Kaiser Permanente researchers currently publish over 1,200 articles each year in various medical journals.¹⁶⁰ One of the Kaiser Permanente research projects looked at the electronic medical record database for a couple million patients to study hospitalized stroke patients. The stroke study identified a very powerful link that existed between the use of the prescription drugs called statins and the death rate for hospitalized stroke patients. The researchers learned that there was a huge impact on the death rate for stroke patients -- depending on whether or not the stroke patients in the hospitals received statins. The death rate differences were significant.

The study learned that when hospitalized stroke patients were not given statins while they were hospitalized, the death rate for those patients was 11 percent. But when those same hospitalized stroke patients were given statins, the death rate dropped to 6 percent.¹⁶¹

So the researchers who were using the new electronic Kaiser Permanente database to look at stroke deaths identified from that vast array of data that the death rate for hospitalized stroke patients could be cut almost in half by giving the stroke patients statins while they were in the hospital. That was very important information. Cutting the death rate for stroke patients in half is obviously an important thing to do.



The researchers also learned that for the stroke patients who survived, the percentage of patients who went home from the hospital either undamaged or lightly damaged was also significantly better for the patient group who received the statins.

That was an incredibly powerful learning. It was possible to do that learning only because Kaiser Permanente has put the electronic medical records in place for all patients that can be used to make that kind of research and learning “easy to do.”

Under the rubric, “Make The Right Thing Easy To Do” -- medical research is obviously very much a right thing to do. Having a database that makes important medical research “easy to do” is even better.

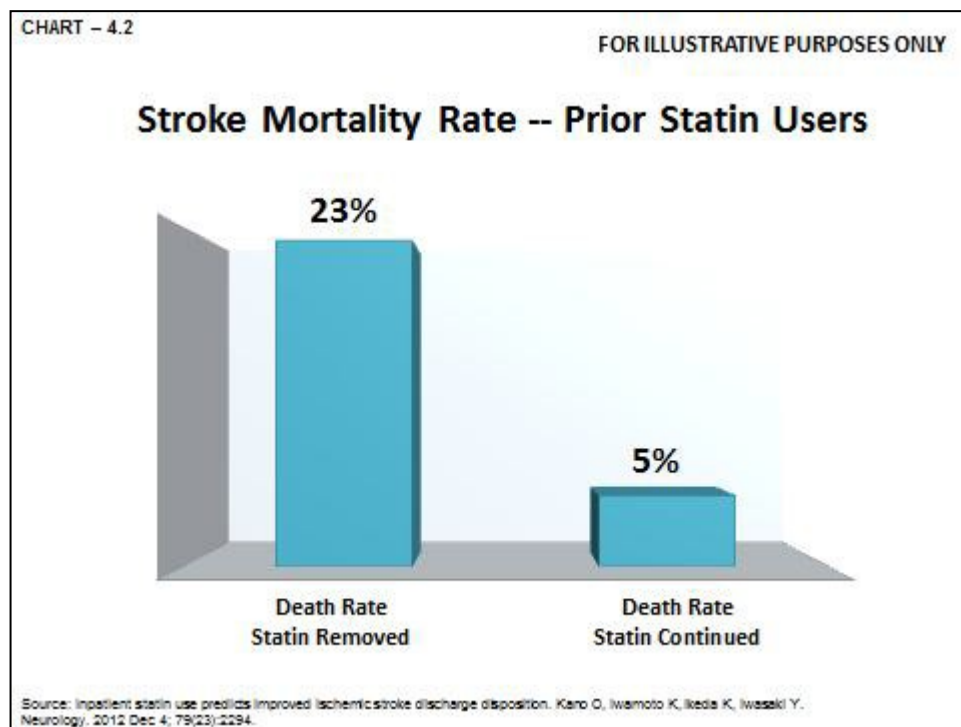
That extremely important learning about cutting the death rate in half for those stroke patients would have been almost impossible to do in a research environment that had to use both pure paper medical records for all patients and small data pools.

Interestingly, cutting the stroke death rate by almost half for all stroke patients, on average, wasn't the most stunning learning that occurred as part of that particular research project. The most stunning data point resulted from the fact that the researchers also looked at the death rates in the hospital for the people who had strokes who had been taking statins before they were hospitalized for their strokes. That information about prior use of statins came from a different part of the electronic medical record. The researchers learned that for those stroke patients who had been taking statins before they were hospitalized and who then continued on with the use of statins while they were in the hospital, the death rate dropped to 5 percent.¹⁶²

Five percent is a very low number. Because Kaiser Permanente has the complete medical records for every patient electronically, the researchers could know which patients had been taking statins before being hospitalized.

In other research settings -- and particularly in any research settings where paper medical records are used as the database -- the analysts doing the research on those patients who died in the hospital typically would have no way of knowing any of that information about any prior use of statins by those patients.

That 5-percent number was the good news. There was also bad news. The bad news was that if the stroke patient had been taking statins before being hospitalized, and if the statins were then discontinued while the patient was hospitalized -- the death rate for those patients jumped to 23 percent.¹⁶³



Twenty-three is a very big percentage. That is a high rate of death. That is incredibly important information. It is particularly important information for any patients who suffer strokes who have been currently taking statins. That number of stroke patients who take statins today is in the millions across the country. For those patients, the research shows that their chances of dying is roughly 1 in 20 if their statins are continued; and their chances of dying is roughly 1 in 4 if the statins are discontinued.¹⁶⁴

So what did Kaiser Permanente do with that extremely important stroke death rate information? How did Kaiser Permanente make the right thing easy to do? The right thing to do for the stroke patients was clearly identified.

As a first distribution point and an important communications approach, that piece of research was published in a highly respected, fully refereed medical journal. The journal of Neurology then shared that research finding with the world through their normal distribution approaches. So Kaiser Permanente shared that new piece of information with as many other caregivers as possible who might be treating stroke patients through publishing that important piece of research in that highly respected and well read medical journal.

That journal-publication approach is not, however, a perfect information distribution system. Some other caregivers in multiple other care sites may have read that journal article, but very many other caregivers who treat stroke patients every day do not read that particular journal and did not read that particular article. Nearly 80,000 other medical journal articles about various research topics were published that year.¹⁶⁵ Obviously, not every journal article gets read by every caregiver. For starters, it is clear that not all caregivers who treat stroke patients subscribe to that journal -- so if that was the only learning tool used to distribute that piece of information, it would not have helped all of the patients who would have benefited from that knowledge.

Inside Kaiser Permanente, both that journal article and the related research were added to the Kaiser Permanente electronic medical library. That was a first communications step inside Kaiser Permanente. In addition, a team of neurological experts analyzed the research, checked out the findings, and then developed a recommended Kaiser Permanente stroke treatment protocol that incorporated that information into the current guidelines.

So, to help make use of that important piece of research information about stroke patients easy to do, a medical best practices protocol including that science was developed, and the protocol was then distributed to Kaiser Permanente caregivers through the Kaiser Permanente electronic medical library.

As noted earlier, most other caregivers in the world do not have an electronic medical library -- so the truth is that relatively very few other caregivers outside of Kaiser Permanente actually received or learned about that piece of information about stroke patients.

That was not, however, the total use of that key piece of information about stroke care inside Kaiser Permanente. That library still needs to be accessed by a caregiver to have an impact on care. There is another level of care support tool inside Kaiser Permanente that can take the learning process one step further. As noted earlier, Kaiser Permanente owns and operates more than three dozen hospitals.¹⁶⁶ In the hospitals that are owned and operated by Kaiser Permanente, that extremely important piece of information about life-saving stroke treatment was also added to the recommended "order set" that is used in the hospitals by the caregivers at the point of care for each stroke patient. "Order sets" are a key functional and

very useful care support tool. They help caregivers make right care easy to do. To make the right thing easy to do for this particular information, that highly important information about recommended “orders” for stroke patients appears on a screen in the hospital for the doctor to review exactly at the point in time when the Kaiser Permanente doctor is treating a stroke patient.

In other hospitals and other care settings, a stroke patient who had been taking statins before their stroke has to hope that their doctors might have seen that research article. The patients in other care sites also have to hope that their doctor might remember to make use of that information for them at that moment in time. Human memory -- simple mental recollection -- is the primary care quality support tool that is used for that kind of medical science reminder in the vast majority of all non-Kaiser Permanente care settings. Memory -- many studies have shown -- is an imperfect and often undependable quality safeguard, and sheer and pure memory obviously isn’t functionally optimal as an anchor of any care or safety process.

By contrast -- at Kaiser Permanente -- the basic research about stroke deaths was read, understood, incorporated into care guidelines, and then that valuable information was also built systematically into the computerized care “prompts” that are used at the point and the site of care to remind the caregivers of that information at the exact time when making that “right thing” easy to do was most important to the patient. Making the right thing easy to do clearly increases the likelihood that the right thing will be done.

Each of those pieces -- computerized care protocols and computerized recommended order sets should be considered by the people who are putting ACOs in place in various care settings. That could be a good time to at least begin that work.

Making the right thing easy to do is also why Kaiser Permanente has developed an extensive, award-winning, mail-based prescription refill program. The new tool kit allows for prescription refills to be either triggered or ordered on the patient’s computer or smartphone.

Why does that fit the category of making the right thing easy to do?

If you want to help prevent heart attacks, asthma attacks, CHF attacks, and strokes, the right thing to do is to get the patients who are individually at the most risk for those conditions to take their medications. In that context, making the right thing very easy to do for the patient who is refilling their prescriptions is a very good care support strategy.

That approach works. Kaiser Permanente has some of the highest prescription refill rates in the nation¹⁶⁷ -- and Kaiser Permanente is seeing reduced numbers of both strokes and heart attacks.

It is much more convenient -- significantly easier for most patients to do -- for the patient to get their prescriptions by mail rather than driving to a pharmacy to get a refill. Last year, Kaiser

Permanente filled more than 30 million prescriptions by mail.¹⁶⁸ The actual, pure energy savings that resulted from those patients not having to drive to a pharmacy to get their drugs actually has its own environmental protection value.

Likewise -- to make the right thing easy to do -- Kaiser Permanente has set up approaches that allow patients to have e-visits with their caregivers. ACOs and medical homes can also both learn from that model. It works well. Patients like the model, and caregivers find it extremely useful. With secure messaging, email visits between patients and physicians can both supplement and replace face-to-face visits for many care situations. Kaiser Permanent had roughly 12 million of those e-visit connections with patients and physicians last year.¹⁶⁹ That information sharing and that direct-patient dialogue with the physician would have required a face-to-face visit in almost all of those piecemeal-reimbursed care settings. The patient would need a face-to-face meeting with a caregiver in a medical office site to get that e-visit information flow and that physician dialogue in almost all other care settings. Each of those face-to-face visits in the fee-based care settings would also have triggered an office visit fee -- ranging from a hundred dollars to a couple hundred dollars.¹⁷⁰ Because Kaiser Permanente doesn't bill for care by the piece, there was no revenue loss to Kaiser Permanente for creating those highly convenient, patient/physician electronic interactions. E-visits clearly make the right thing easy to do for patients.

Again -- looking at the rest of the world -- when millions of additional low income and minority people will get insurance of one kind or another for the first time at the beginning of next year, having care sites available to those patients that can offer e-connections for patients instead of just face-to-face visits, would clearly be a very good thing for many newly insured patients. The logistical conveniences of those visits could be particularly useful for low income patients. Low income people often face transportation difficulties. Those difficulties can be mitigated for many people by having some care contacts with their care teams be done electronically rather than just having all care contacts happening as face-to-face visits in the physician's physical care sites. That would make the right thing easy to do for those patients -- and making the right thing easy to do is a highly useful guideline for the new ACOs and medical homes to follow.

3) Continuously Improve

Continuous improvement is another key guideline at Kaiser Permanente. The third Kaiser Permanente guideline that should be relevant and useful to ACOs and medical homes as this country begins to reorganize the way we both deliver and buy care in this country is to "continuously improve." Continuous improvement is an approach to care that has huge value. Dealing with the issues of care differences and care disparities is much more likely to be successful in the context of continuous improvement for care delivery.

Continuous improvement is now a core philosophy for Kaiser Permanente planning functionality and operations. Most of health care in this country is delivered today in care sites that are heavily focused on maintaining, protecting, and preserving their status quo. Process change is rare. Very few care sites in America have set up formal processes and built the skill sets that are needed to achieve continuous improvement. Continuous improvement, done well, involves gathering data, measuring results, and taking appropriate steps in a formal, systematic way to improve the results of any process.

Continuous improvement -- done really well -- reaches beyond simply improving current processes and extends to inventing new approaches and new processes where a significant level of change is needed to continuously improve care delivery.

For hospital-acquired pressure ulcers, for example, the continuous improvement process started with measuring the number of ulcers that were happening. Once the initial measures were identified, teams of caregivers began figuring out ways of reducing the number of those ulcers. Standard care approaches -- like continuous inspection by caring nurses of the skin health of each and every high-risk patient -- were developed, applied, implemented, tested for effectiveness, and then continuously improved. Best practices were developed and shared. As noted earlier in this book, the percentage of patients in Kaiser Permanente hospitals with those ulcers dropped over time from nearly 4 percent of the patients to less than 1 percent.¹⁷¹ Improvements in treatments, skin care medications and even buildings and equipment were all added to that approach over time in a process of functional continuous improvement.

Continuous improvement is more than goal-setting.

The functional continuous improvement approach that is used by Kaiser Permanente for care improvement is not just to set a goal for some area of performance, achieve the goal, and then declare victory. The approach used at Kaiser Permanente in most settings is to set a direction for improvement and then continuously improve. Pressure ulcers are a good example. Continuous improvement for that particular category of care has worked to the point where several Kaiser Permanente hospitals have not had one single stage 2 pressure ulcer in over a year.¹⁷²

Again, the fact that Kaiser Permanente sells care by the package -- very much like the new ACOs hope to do -- instead of just selling care by the piece, creates a very different business model. In those piecemeal payment settings, where care is sold by the piece and not by the package, reducing the number of pressure ulcers to zero could actually result in a significant reduction in hospital revenue.

However -- and this is the important point to recognize -- if those hospitals were paid a flat ACO payment that was level and fixed per patient, that lump sum payment approach does not create any new revenue for a hospital when patients get those ulcers. Continuous improvement processes could become a functional reality in those ACO settings -- and the number of additional hospitals in other care settings who would also be able to achieve zero ulcers for

their patients would probably increase significantly. Continuous improvement clearly works best when that care is sold by the package and not by the piece.

Continuous-improvement thinking and approaches can be seen in all of the overall continuously improving results that were shown on all of the performance charts in Chapter Two of this book. Care obviously got better for each condition, each year. The performance levels did not get to a point where the fact that Kaiser Permanente had the best levels in the country in some areas was good enough. “Best” is not the goal of continuous improvement. The goal of continuous improvement is to do better than best. Getting better is the key and ongoing goal. A widely stated adage inside Kaiser Permanente that functions as a subset and a corollary to the overall continuous improvement agenda is for Kaiser Permanente to be, “The Best at Getting Better.”

Being “The Best at Getting Better,” is also a very self-reinforcing goal. That is another important learning for the new ACOs and medical homes. When people believe that being the best at getting better is their operational goal, that goal liberates people to first figure out new ways of doing things and then to figure out even better ways of doing things. Again, the fact that Kaiser Permanente is not confined to only delivering the care that is defined by the pieces of care that are listed on a standard Medicare fee schedule helps immensely with flexibility and creativity relative to continuous improvement.

The current fee schedule for most payers deals with various aspects of care process flexibility in some obviously perverse ways. Cutting pressure ulcers to less than 1 percent of patients does not have one single fee-schedule trigger for a typical, standard, insurance-company-approved payment procedure scale. Having the nurses in each hospital carefully checking the skin of every patient repeatedly is a wonderful and highly effective thing to do -- but that work by those nurses does not generate a fee for any of the piecework-based care sites when the nurses do that work. Pressure ulcers can obviously create revenue from private insurers in a piecework setting. The work done to prevent pressure ulcers does not create revenue from those private insurers in those same settings. That is a bad way to buy care. The inherent perversity of that payment model is fairly obvious to anyone who looks closely at how we usually buy care in this country today.

There are 1.7 million Americans who get infections in hospitals every year that they did not have on the day they were admitted to the hospital.¹⁷³ Those infections can each trigger a lot of money for the hospitals where the patients were infected. Hospitals are all very ethical. Hospital leaders are all good people. Hospital medical directors are all good people. No hospital in this country would ever give any patient an infection deliberately. Never. None. That does not happen. That will not happen. But when no one pays for all of the work that is needed to effectively prevent those infections, it is also true that the work needed to prevent those infections tends not to get done in too many places -- unless you happen to be in a care setting like Kaiser Permanente where the care is sold as a package and not by the piece.

As noted earlier, the good news is that the new ACOs are likely to put continuous improvement processes in place, and care safety programs in operation that will trigger both prevention and rapid and effective response work if the payment model is set up appropriately to reward the consequences of better care. That level of successful prevention work is entirely possible to do. As a prototype ACO, Kaiser Permanente is proving today that it can be done.

The functional and operational approach that guides the care delivery infrastructure of this country needs to be continuous improvement -- not maximizing revenue streams and optimizing billing units.

4) Focus on the Patient

Focusing on the patient is the fourth guideline.

A major Kaiser Permanente guideline for planning, operations, and systems design that also deserves to be understood and replicated in various settings is focusing on the patient. That guideline also ought to be incorporated into the foundational structure of the new ACOs and medical homes. Patient focus is a key planning guideline and a major objective of the care system at Kaiser Permanente. Patient focus also seems like an obvious goal to many people, but it is not how most health care systems and most care infrastructure pieces in this country are designed today. For many areas of functionality, most care settings are designed almost entirely around the business needs of the caregivers. Systems that exist are set up primarily to generate bills, and those billing-based systems only keep track of the data about the actual pieces of care that were delivered to a given patient at that specific care site. Very few systems are set up to link with one another in any way when a given patient has multiple caregivers. Very few systems or processes are set up by care sites to provide any data other than the information that is needed at that specific care site to deliver the site-specific pieces of care and to generate and process an insurance claim. The data that does exist in those care sites is almost entirely focused on each piece of care that was delivered -- not on the actual patient.

At Kaiser Permanente, by contrast, because the overall Kaiser Permanente care system is responsible for the total care needs of a full population of patients, the database and data flow are both set up with the patient at the core. That is actually a very useful and functional way to organize care data.

As noted earlier, the foundation and the anchor for all care data at Kaiser Permanente is the patient. The medical records for each patient are computerized, and all data from all systems about the care for each patient flows to that medical record. The lab systems run their tests, generate their reports, and that report data then goes from the lab system to the doctor and also flows electronically into each patient's activated medical record. Diagnostic and treatment information are not kept in separate files at Kaiser Permanente that are splintered and

segregated by medical specialty or by care site. All of that information from all of the tests, the labs, and the care sites is kept as a total, patient-focused package in each patient's medical record.

That is a very practical way to use and file data.

That patient focus means that all of the data needed by the caregiver is available when it is needed at the point of care. That data collection approach also means that the computer can screen each patient's data files to see if all needed tests were done -- or if the patient is current on their prevention and on their personal, early detection and early intervention agendas.

The computer can even do very sophisticated screenings to look for unmet care needs. That can be particularly useful when the goal is to close care gaps and end disparities in care. There is no possible way to do that kind of systematic care process improvement work without an electronic medical record and without a data system that focuses on patient-specific data to identify care needs in a systematic way.

Some care systems and care sites who do implement electronic medical records for their own care business units put electronic records in place that are segregated by care site or by medical specialty. Both of those approaches are clearly inferior to an approach where the care delivery and the care data are focused on the patients and all patient data is accessible through a single tool for each patient.

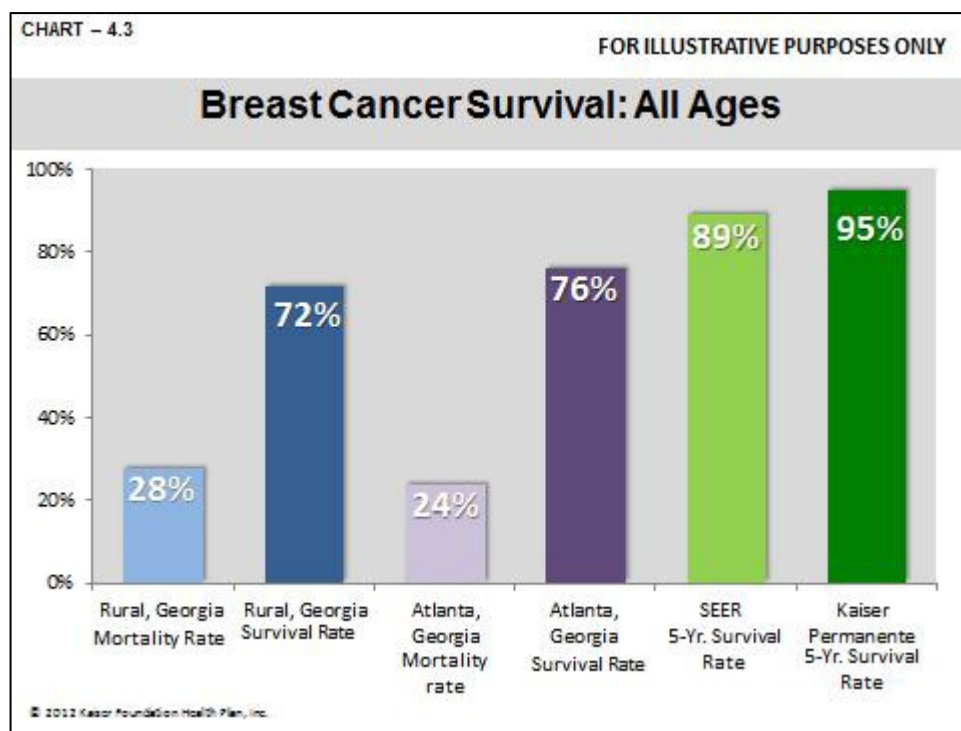
5) Data Availability -- Data Transparency

Data needs to be both transparent and available.

The fifth Kaiser Permanente guideline and systems design goal that should be understood and probably followed by other care sites that are trying to improve care is to create both data availability and data transparency inside the organization or care team. Data about care is a wonderful thing to have. As noted earlier, health care in this country tends to be almost data free. There actually are huge deficits relative to both data gathering and data sharing in American health care delivery. Most patient data tends to be both splintered and inaccessible. Comparisons of all kinds are functionally impossible. Most care sites do not even know their own success levels and their own mortality rates for multiple health conditions -- much less knowing how their own performance compares with other caregivers who are treating people with the same health conditions.

That data void is a problem because there are significant variations in care performance levels.

The truth is that your personal chances of dying from cancer can double or triple, based on the care site you use. When you look at the five-year survival rates for breast cancer, the very best care sites have about a 5 percent mortality rate, and the very worst care sites have more than a 15 percent average mortality rate.¹⁷⁴ The bar chart below shows four numbers. One bar is the most recent breast cancer mortality rate in rural Georgia. The second bar shows the breast cancer mortality rate for cancer patients in Atlanta, Georgia. The third bar shows the breast cancer survival rates -- on average -- in the various cancer sites that participate in the SEER national cancer reporting database that was mentioned earlier in this book. The fourth bar on the chart shows the average five-year survival rate for breast cancer cases at Kaiser Permanente.



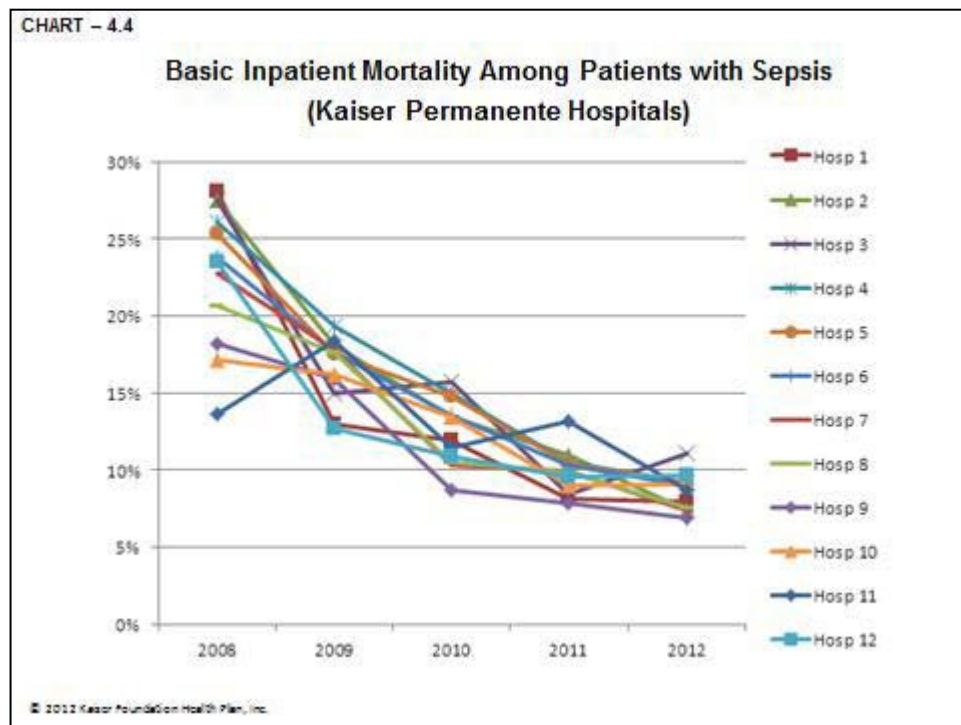
There are some clear care disparities on this chart. Care is not the same everywhere. Care outcomes vary significantly. Too many caregivers do not even know how their outcomes for their own patients compare with the outcomes for patients at other care sites. It is hard for those sites to improve their care -- because they don't know how much improvement is possible. Patients should know what the potential survival rate differences are for key areas of care. In this particular case -- for cancer of the breast -- some of the major disparities for cancer survival rates are by geography and care site. Patients -- and particularly breast cancer patients -- need to know that these kinds of outcome differences exist.

Cancer isn't alone in having variable success levels for different care teams. The death rate varies by more than 60 percent for heart attacks between various hospitals.¹⁷⁵ For heart bypass

surgery, the worst care sites have a death rate that is more than eight times higher than the death rate at the best care sites.¹⁷⁶

Good Intentions Are Not as Good as Good Data

What is really unfortunate is that many of the low performing care sites have no clue about how badly they are doing. They have no clue because they do not have data. If those care sites sometimes do have some data, they often have only a snapshot piece of data. Single and isolated data points are not very valuable as the basis for any kind of continuous improvement activities for any care sites. Care can get a lot better when comparative data exists. Remember the sepsis care experience described earlier. The dozen hospitals that were listed on the sepsis mortality chart shown earlier, and shown again here, had no clue how well or badly they were each doing before the data was recorded.



Before this data was gathered, all hospitals believed they were delivering great sepsis care.

The worst hospitals on this chart believed very sincerely, when this data was first gathered, that they were doing really good work with sepsis patients. The hospital teams were all very good people. They all knew very good approaches to sepsis care. They all knew the basic science of sepsis care. They were -- as a group -- extremely well-intentioned. It's hard to be better intentioned. But good intentions are not as good as good data when it comes to functionally saving lives.

The process of care improvement for sepsis deaths in those hospitals took more than data. It required transparency. To use that data really well, the hospitals first needed to share it with one another. If Hospital A only has the current data for Hospital A, there is no way of Hospital A knowing whether their performance is good or not good. Multiple data sources are needed to gain that insight. Comparisons are golden.

Sharing is also golden at multiple levels. The hospitals who had the lowest death rates for sepsis shared their best practices with the hospitals with lower success levels. That sharing process not only helped the poor performers -- it helped the good performers get better because they all learned from each other. Hiding data and not sharing data is not a good thing to do. A lot of people would literally be dead today if the 12 hospitals on this chart had hidden their data and not shared it with one another.

Sepsis is the number one cause of death in hospitals.¹⁷⁷ Cutting the death rate by two-thirds or more could have a large impact on overall hospital mortality rates in this country. We need all hospitals sharing their data about a wide range of mortality issues -- and care will get better when that happens.

In some ways, as noted earlier in this book, the most important success that results from the sepsis care improvement is that the patients who do survive in the best hospitals tend to be much less damaged than the patients who survive less effective sepsis care in the worst hospitals. Patients in the worst hospitals are much more likely to be damaged for life by their sepsis. That is another area of commonplace that can trigger life-long disparities by race and ethnicity that damage patients. That long term sepsis damage can be particularly debilitating for low income patients who have no financial resources to use to give themselves needed extra levels of support when they return badly damaged to their homes. There are significant subsequent disparities that happen at very basic economic levels when patients go home damaged by slow and inadequate sepsis care or by inferior and inadequate stroke care or pressure ulcer care.

We Need Data to Address Disparities

We will not be able to reduce disparities in this country if we don't have good data to let us know when disparities exist.

The key point of this section of the book is that we really do need good, solid, accurate, timely and actionable data about care performance -- and we need that data to be transparent between caregivers so we can make the kinds of informed decisions we need to make about continuously improving care across all populations. We very much need that data so we can reduce the disparities in care delivery that exist today. We need to define those disparities, understand them, identify where they happen, and take steps to mitigate and prevent them.

A major, recent study was released as -- “Predominately Black Hospitals Provide Poor Trauma Care.”¹⁷⁸ The study showed that victims of trauma care were at much higher risk of dying if they were treated in hospitals that had a high number of Black patients. That level of performance needs to be corrected. Care in those hospitals will only improve when the care performance levels are visible to the caregivers and when the care processes in those care sites are systematically improved.

Kaiser Permanente has put together a database about care delivery that gathers that kind of data and uses it for those specific purposes. That approach can succeed. Care clearly gets better when that data use happens. The experiment that will determine whether or not data supported care improvement is good to do has been done. That approach is a good one, and it is obviously the right thing to do. The experiment of whether that entire database and systematic care improvement work can be used to prevent, alleviate, mitigate, and overcome the disparities that continue to exist in care delivery is a work in progress. It appears that progress is possible -- and we really need to learn from both our failures and our successes on those agendas.

6) Be Us -- Eliminate Disparities

The final Kaiser Permanente guideline that can be used to help American health care organizations and health plans address the issues of care disparities and care differences is to create an explicit and collective commitment for the care team to deliver the right care for all members of the patient population -- regardless of race, ethnicity, age, sexual alignment, or gender.

As you can see from the data that was shown earlier in this book -- with particular reinforcement from the care results that relate to HIV/AIDS patients and best care delivery -- it is important to make both care equity and care quality a key and explicit agenda of the care teams. It is important for care teams to think of all patients as being a collective part of who each care team is -- not seeing patients as separate sets of people who are defined by their race and ethnicity. It is a good thing to be inclusive in our thinking and to deal with all patients as being part of us -- included in our broad definition of who we are as caregivers and people.

That work of being inclusive is so important. That particular guidance is a separate chapter of this book. It is the next and final chapter.

Read on.

