Esperienze di successo: Kaiser permanente HMO

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FONDAZIONE ACTION FOR HEALTH INSTITUTE

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Congresso Nazionale 2019

CNETO, Fondazione Action for Health Institute, Politecnico di Milano, ABC...Salute

Dare valore alla salute

Dalla medicina curativa alla medicina proattiva
Nuove strutture e sistemi integrati per la salute

Patrocinato e supportato da

NOVEMBER 10, 2019

Kaiser Permanente mourns

It is with profound sadness that we announce that Bernard J. Tyson, Chairman and CEO of Kaiser Permanente, unexpectedly passed away early Sunday morning in his sleep.

Learn more

HMO – HEALTH MAINTENANCE ORGANIZATION

- HMO è l'acronimo che definisce «organizzazione per il mantenimento della salute»
- Corrisponde ad un piano assicurativo sanitario a costi prevalentemente «calmierati»
- Esistono varie organizzazioni strutturate in HMO con costi ed offerta di servizi diversi
- Sono fondamentalmente ispirate al principio della managed care : l'iscritto viene inserito in percorsi di assistenza sanitaria predefiniti , in un network stabilito con un «gate keeper» che governa l'accesso ai diversi servizi/livelli di intervento
- Accesso ad HMO è spesso limitato alla condizione di lavoratore dipendente da compagnie che offrono adesione al programma
- Alcune HMO garantisco accesso «pubblico» , svincolato cioè dalla posizione lavorativa dell'assicurato
- Vengono spesso confrontate, sulla base dell'offerta di servizi con le PPO (preferred provider organization), corrispondenti a pacchetti assicurativi più «liberi» e costosi

KAISER PERMANENTE

1933 – avvio
Dott. Sidney Garfield

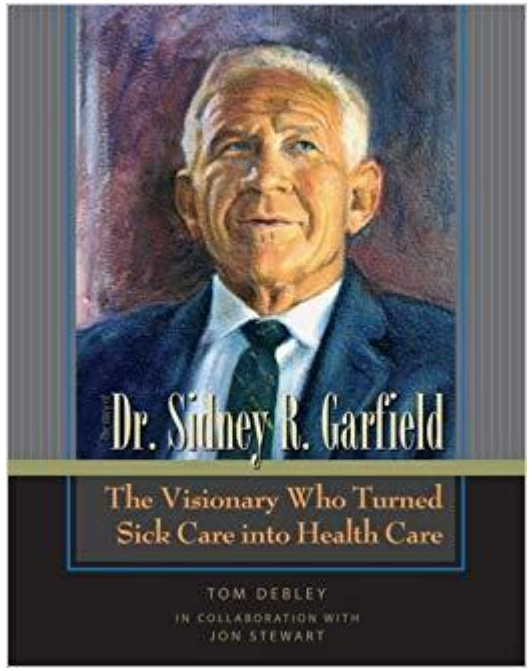
1938 – 1945 inizio
Partnership con
Henry J. Kaiser

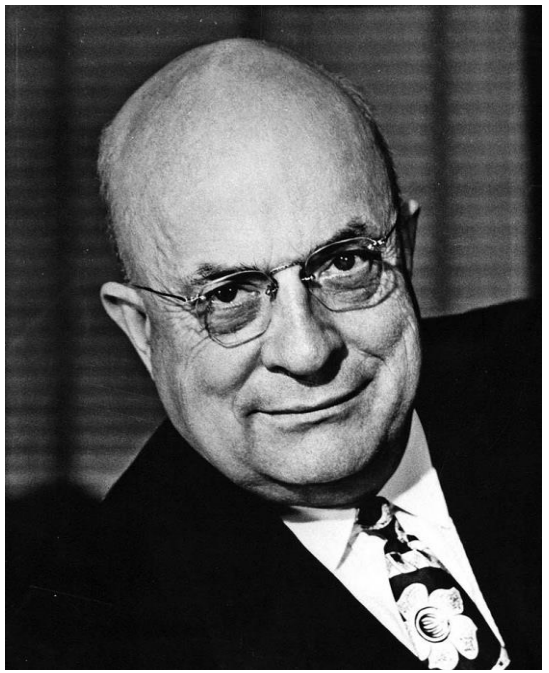
1945
apertura al pubblico

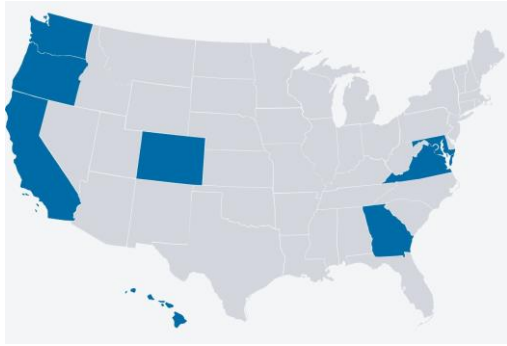
1953 – nasce il brand
Kaiser Permanente

1973 – R. Nixon
Health Maintenance Organization Act

Oggi
12 milioni di iscritti in 8 stati







DA COSA NASCE L'INTERESSE PER KAISER PERMANENTE HMO

CONFRONTO NHS VS KAISER PERMANENTE

BMJ VOLUME324 19/01/2002

Papers

Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente

Richard G A Feachem, Neelam K Sekhri, Karen L White

Abstract

Objective To compare the costs and performance of the NHS with those of an integrated system for financing and delivery health services (Kaiser Permanente) in California.
Methods The adjusted costs of the two systems and their performance were compared with respect to inputs, use, access to services, responsiveness, and limited quality indicators.
Results The per capita costs of the two systems, adjusted for differences in benefits, special activities, population characteristics, and the cost environment, were similar to within 10%. Some aspects of performance differed. In particular, Kaiser members experience more comprehensive and convenient primary care services and much more rapid access to specialist services and hospital admissions. Age adjusted rates of use of acute hospital services in Kaiser were one third of those in the NHS.
Conclusions The widely held beliefs that the NHS is efficient and that poor performance in certain areas is largely explained by underinvestment are not supported by this analysis. Kaiser achieved better performance at roughly the same cost as the NHS because of integration throughout the system, efficient management of hospital use, the benefits of competition, and greater investment in information technology.

Introduction

The NHS Plan for 2000 states: "The NHS is effective and efficient at meeting its goals. The NHS gets more and fairer health care for every pound invested than most other health care systems."[1]

We examined this claim by comparing the costs and performance of the NHS with those of a non-profit health maintenance organisation (Kaiser Permanente) in California. We compared the NHS and Kaiser Permanente on a macro level to identify any large scale differences in efficiency and operational effectiveness that would be relevant to policy and to identify topics for further research. We have not examined the merits of the overall healthcare systems in the two countries.

Comparisons among health systems are difficult because of the complexity of the systems and their contextual specificity. Several authors have made country-level international comparisons using data from the Organisation for Economic Cooperation and Development (OECD)[2] or the World Health Organization.[3] Comparative studies usually conclude that the United States has high costs and poor population health outcomes. Beneath this accurate overall observation, however, lies the multiplicity of different healthcare systems operating and often competing within the United States.[4]

In many ways Kaiser Permanente is like the NHS, providing a similar range of services for a population equivalent to that of a small country. Founded in 1945, it is roughly the same age as the NHS and has had the same amount of time to evolve and adapt to new circumstances. Kaiser Foundation Health Plan and Hospitals are integrated with independent physician group practices called Permanente Medical Groups. The health plan is the insurance arm of the organisation, while the hospitals and medical groups provide all clinical services. To the public these entities are seen as one organisation, which is commonly referred to as Kaiser. Kaiser has 8.2 million members: 6.1 million in California and the remainder in Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington, and the District of Columbia.[5] We compared Kaiser's California region with the NHS because it represents the model most similar to the NHS. In California, doctors in the Kaiser system (both primary care and specialist) are shareholders or partners and salaried employees of the medical groups, and Kaiser owns and operates most of its own ambulatory facilities and hospitals. Unlike the NHS, Kaiser specialists cannot work outside the system.

Methods

We focused on cost and performance. We measured cost by determining the total operating costs of each system and by adjusting the benefits offered, special circumstances not common to both systems, the relative costs of the medical environment in which the two systems operate, and the age and socioeconomic characteristics of the populations served. We measured performance by comparing inputs, access to services, responsiveness, and limited quality indicators.

In the 1940s the NHS inherited a large stock of hospitals and facilities whereas Kaiser has had to develop its infrastructure from scratch. While noting the different balance between maintenance and capital investment

Editorial by Smith

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BMJ 2002;324:135–43

Principali criteri di confronto:

- Popolazione simile:
  - Assistiti KP della California (6mln) vs
  - Assistiti NHS di una media contea britannica
- Analisi costi
- Misurazione performance servizi principali :
  - Tempi attesa
  - Accesso visite specialistiche
  - Durata ricoveri ospedalieri
  - Accesso a programmi di medicina preventiva

CONFRONTO NHS VS KAISER PERMANENTE

What is already known on this topic

Comparisons of healthcare systems in different countries have to be undertaken with great care but can be instructive

The overall healthcare system in the United States is more expensive than the NHS and population health outcomes are no better

The US healthcare system comprises many discrete and unique subsystems, including the health maintenance organisations

What this paper adds

An integrated, non-profit health maintenance organisation in California (Kaiser Permanente), with over six million members, costs about the same as the NHS but performs considerably better

Kaiser's superior performance is mainly in prompt and appropriate diagnosis and treatment

These findings challenge the widely held view that the NHS is efficient and that its inadequacies are mainly due to underinvestment

Conclusions The widely held beliefs that the NHS is efficient and that poor performance in certain areas is largely explained by underinvestment are not supported by this analysis. Kaiser achieved better performance at roughly the same cost as the NHS because of integration throughout the system, efficient management of hospital use, the benefits of competition, and greater investment in information technology.

CONFRONTO NHS VS KAISER PERMANENTE

Table 1 Comparison of costs in the NHS and Kaiser

Category	NHS (2000/2001)	Kaiser, California (2000)
Gross expenditures/revenue	£58 500m	$14 200m
Less capital depreciation	£1 000m	$557m
Less profit	0	$668m
Operating expenditures	£57 500m	$12 975m
Adjustment for differences in benefits and special circumstances:		
Dental	£1 190m	$10m
Long term psychiatric care	£3 250m	Not covered
Special circumstances	£3 587m	$1 065m
Supplementary private health insurance	£2 630m	0
Net expenditure after adjustments	£52 103m	$11 900m
Per capita expenditure (59.5 million people for NHS; 6.1 million people for Kaiser)	£876	$1951
Conversion to dollars*	$1402	$1951
Adjustment for PPP (1.52)†	$2130	$1951
Adjustment for age (decreases NHS costs by 12.2%) and socioeconomic group (decreases NHS costs 5%)	$1764	$1951
Final adjusted per capita expenditure	$1764	$1951

Table 3 Comparison of inputs and use in NHS and Kaiser, 2000

Inputs	NHS	Kaiser, California
Specialists per 100 000 people		
Pediatricians	4.9*	12.3
Obstetricians-gynaecologists	4.1*	8.3
Oncologists	0.9*	1.7
Radiologists	4.3*	6.0
Cardiologists	0.8†	2.4
Primary care facilities		
Percentage of primary care physicians in single handed practices	9%‡	0%
Average No of primary care physicians per office	3-5‡	20-40
Percentage of primary care physicians with laboratory, imaging, or pharmacy on site	25%-pharmacy (few with other services)	>95%
Percentage of primary care physicians connected to clinical IT system	100% by 2002	>95% today
Use		
Average acute length of stay (days)	5.0§	3.9
Acute bed days per 1000 per year	1000	270

CONFRONTO NHS VS KAISER PERMANENTE

Comparison between the NHS and Kaiser Permanente*

	NHS (England)	Kaiser Permanente
Prevention (%):		
β Blockers after myocardial infarction [3 1]	42 (42)	38 (93)
Mammography†	71 (69)	73 (78)
Cervical screening†	91 (84)	72 (80)
Diabetic retinal examination[6]†	68 (60)	68 (70)
Three vaccinations with DTP and polio	95 (95)	88 (91)
Productivity (No of procedures):		
Angiograms per cardiologist	47.5	48.3
CABG per cardiologist	58.7	52.9
Caesarean sections per obstetrician	58	27

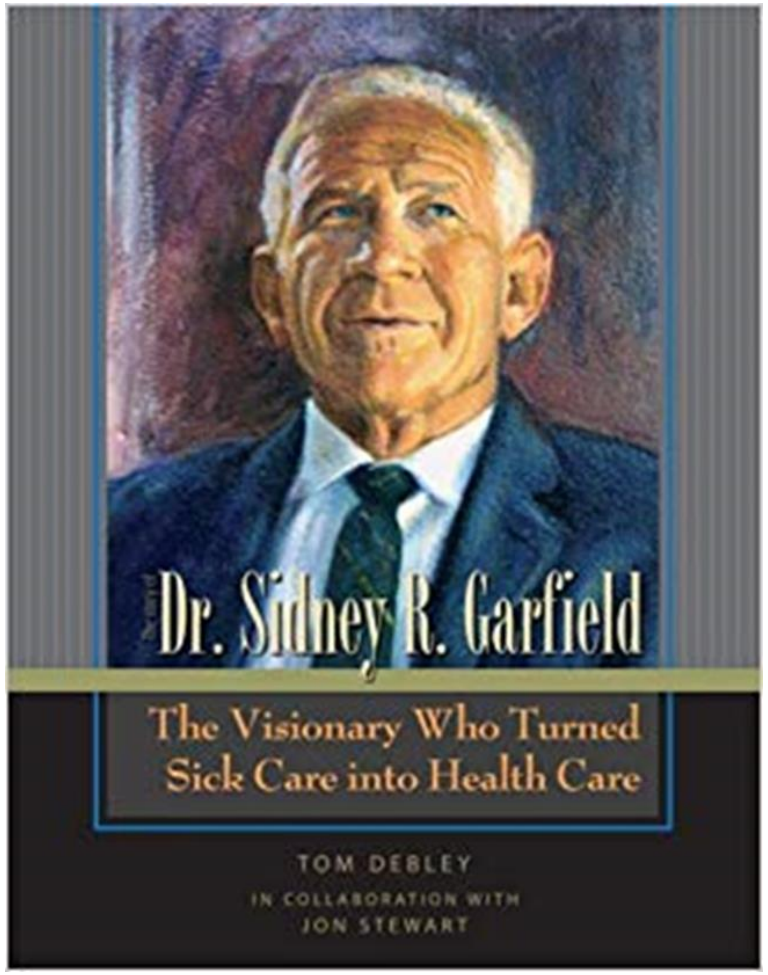
*Numbers in parentheses are original data. †NHS data exclude people within one year of changing practice; Kaiser data include uninsured people. DTP=diphtheria, tetanus, and pertussis. CABG=coronary artery bypass grafts.

Table 4 Comparing responsiveness of NHS and Kaiser to consumers, 2001

Measure	NHS	Kaiser, California
Primary care		
Time to see a primary care doctor	2001: average 3 days; <48 hour by 2004	Urgent: <24 hours; routine: 80% <7 days
Telephone helpline and associated services	NHS Direct helpline available. By 2004, NHS Direct will provide one stop gateway to advice, appointments, and out of hours care	24 hour hotline available for advice and appointments. Appointments can also be made on line
Repeat prescription available without calling or visiting a doctor	Available nationwide by 2004	Available today
Time spent with primary care doctor	8.8 minutes*	Medical: 20 minutes; obstetrics/gynaecology: 15 minutes; paediatrics: 10 minutes
Specialist referral		
Waiting time to see specialist	2001: 36% <4 weeks, 20% >13 weeks, 4% >6 months; by 2005, average 5 weeks and maximum 3 months	2001: 80% <2 weeks
Waiting time for inpatient treatment or surgery	2001: 41% <13 weeks, 33% >5 months, 7% >12 months; by 2005: average 7 weeks and maximum 6 months	2001: 90% <13 weeks
Patient convenience		
Patients' ability to book appointments and admissions to suit own schedule	2001: minimal; by 2005: universal	To a high degree
Availability of translation services	By 2003: available by telephone	Available on site and by telephone

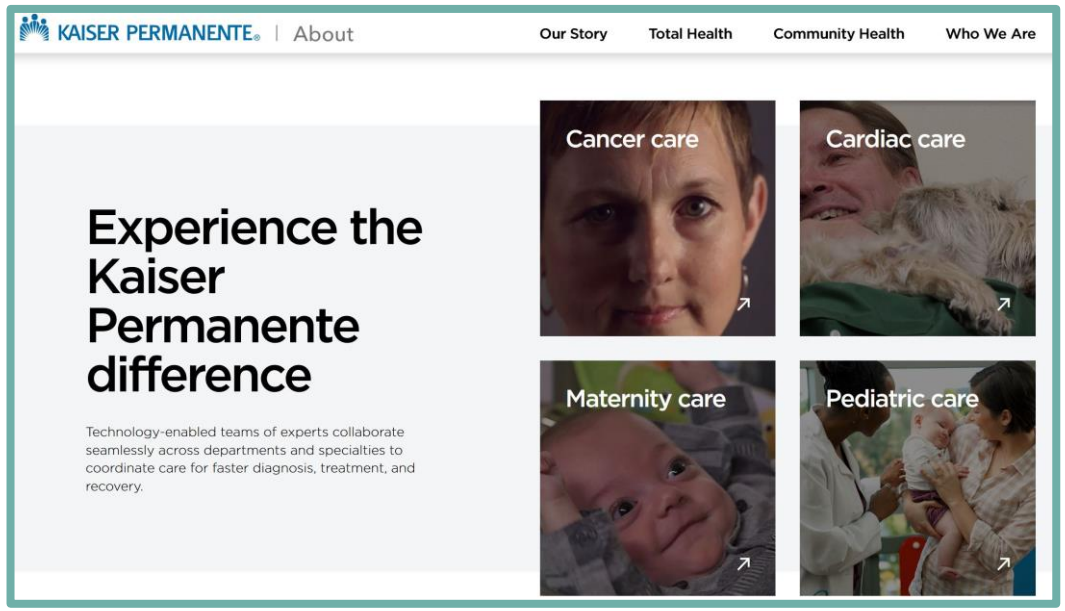
Sources: NHS Plan,[1] Office of Health Economics,[25] Department of Health,[28] and unpublished Kaiser data.
*1992/93 survey.

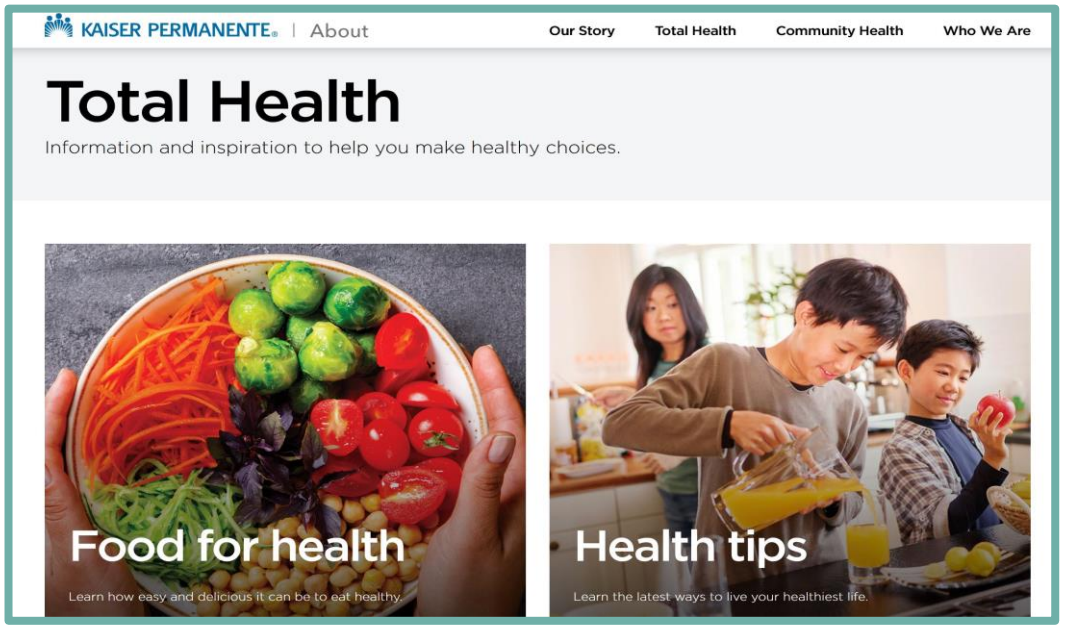
KAISER PERMANENTE

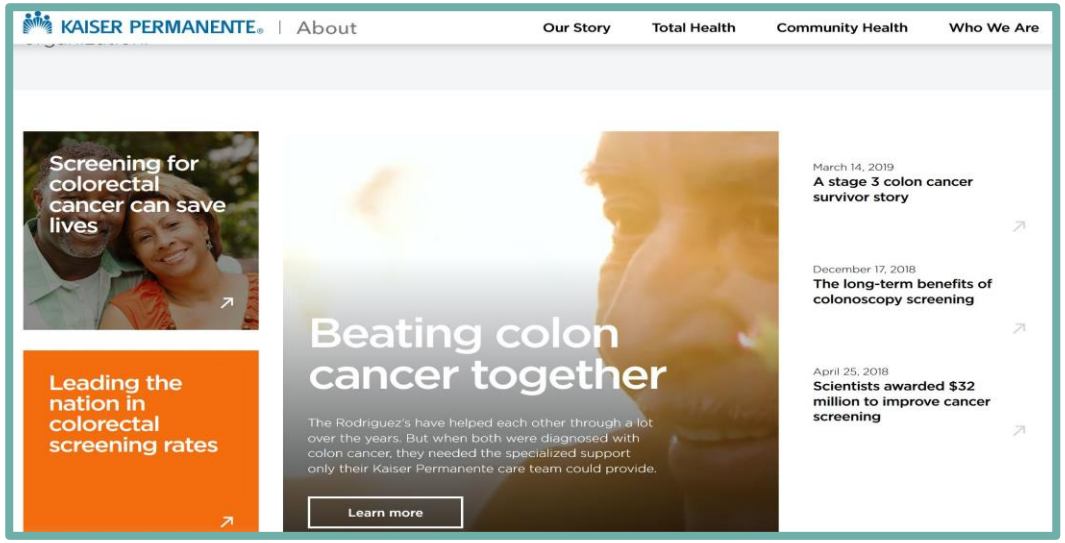


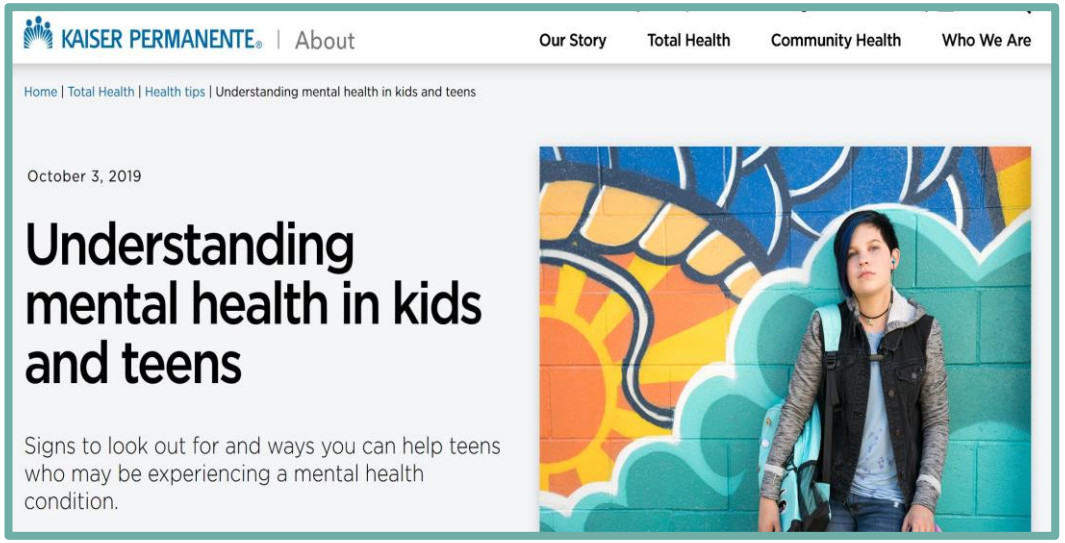
- **Sistema di cure primarie strutturato ed efficiente**
  - **Primary care facilities con 20-40 medici associati, terapisti ed infermieri di comunità**
  - **Dotati di servizi specialistici (laboratorio, radiologia e farmacia)**
- **Medicina di iniziativa e Population Based Management : prevenzione e gestione proattiva patologie, con strategic goals:**
  - **Prevenzione primaria**
  - **Prevenzione secondaria (screening oncologici)**
  - **Gestione malattie croniche**
- **Sistema di monitoraggio dei tassi di copertura di ogni singolo intervento per gli assistiti (members need to reach benchmark)**
- **Forte integrazione tra cure primarie e assistenza ospedaliera (sistema ICT evoluto, figure professionali ad hoc - hospitalist)**
- **Chronic Care Model**

KAISER PERMANENTE

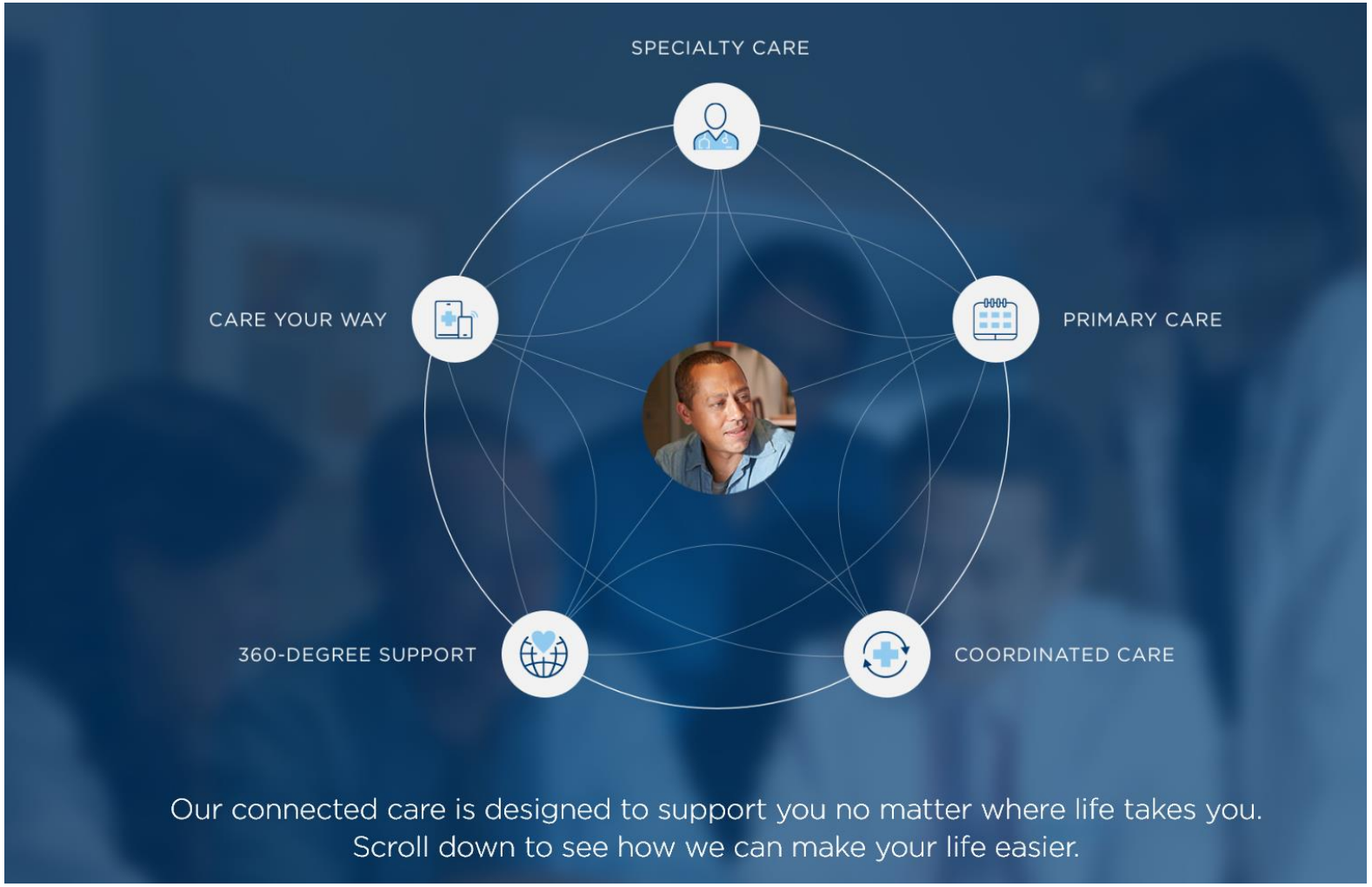








KAISER PERMANENTE



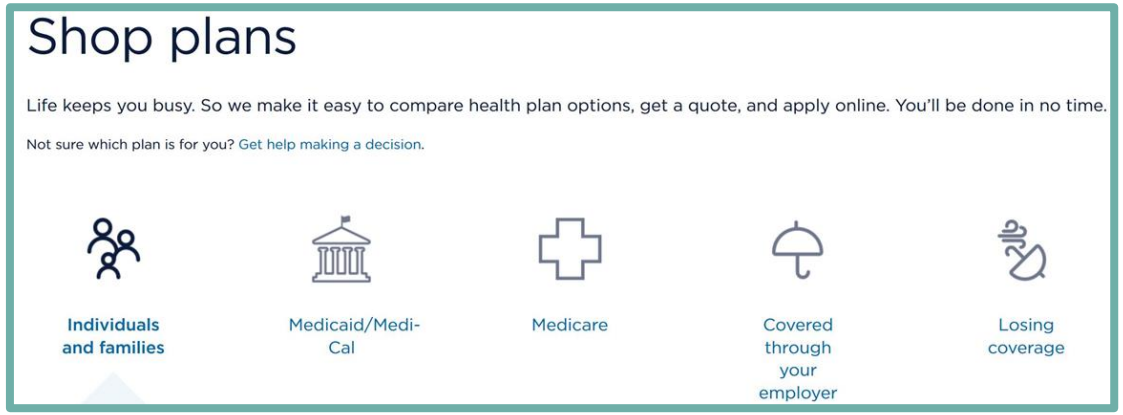
KAISER PERMANENTE

We believe that everyone has a right to good health.

Ensuring health access means serving those most in need of health care through Medicaid, medical financial assistance, charitable care, and other forms of subsidized care and coverage. It also means connecting people with wrap-around social services, healthy meals, affordable homes, safe playgrounds, and supportive schools.

For many low-income people without access to health care coverage, or for those who lose their jobs and can't maintain health care coverage, an emergency room is often the only place they receive care.

At Kaiser Permanente, we're working to change that with programs that lower financial barriers by providing deeply subsidized health coverage and medical financial assistance for care. We also provide information about how to access and qualify for public programs such as Medicaid and financial assistance through the marketplace to individuals who may be eligible.



KAISER PERMANENTE

KAISER PERMANENTE

CHARITABLE HEALTH
COVERAGE PROGRAM

option for you.

What is Charitable Health Coverage?

Kaiser Permanente's CHC programs provide health care coverage to low income individuals and families who don't have access to other public or private health coverage.

When you are a CHC member you receive:

- Enrollment in a Kaiser Permanente Individuals and Families health plan
- A Kaiser Permanente subsidy to help pay your monthly premiums and most out-of-pocket medical costs for most care at Kaiser Permanente facilities

KAISER PERMANENTE RELAZIONE ANNUALE 2018

Medical Facilities and Physicians

Hospitals:	39
Medical Offices:	706
Physicians: Approximate as of December 31, 2018, representing all specialties	22,914
Nurses: Approximate as of December 31, 2018, representing all specialties	59,127
Employees: Approximate, representing technical, administrative and clerical employees and caregivers	218,297

Health Plan Membership, by Region

Northern California:	4,381,752
Southern California:	4,602,747
Colorado:	637,523
Georgia:	309,212
Hawaii:	254,246
Mid-Atlantic States (Va., Md., D.C.):	749,619
Northwest (Ore./Wash.):	620,561
Washington:	697,070

KAISER PERMANENTE RELAZIONE ANNUALE 2018

Annual Operating Revenue

2018: $79.7 billion

2017: $72.7 billion

2016: $64.6 billion

2015: $60.7 billion

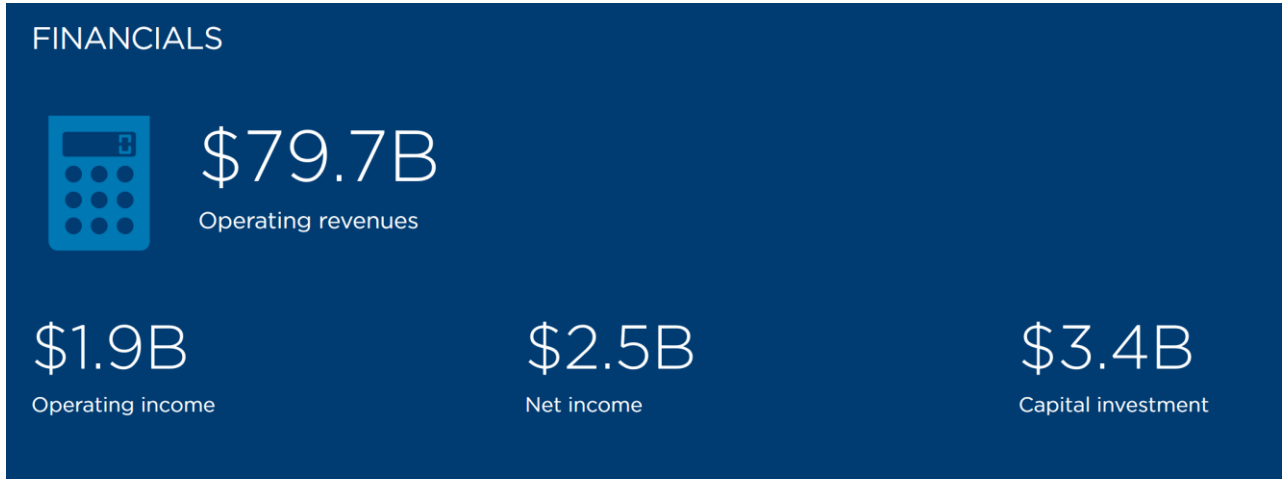
2014: $56.4 billion

2013: $53.1 billion

2012: $50.6 billion

2011: $47.9 billion

2010: $44.2 billion



KAISER PERMANENTE RELAZIONE ANNUALE 2018

HEALTH

120K
Babies delivered

47M
Doctor's office visits*

143K
Inpatient surgeries*

2M
Colorectal cancer screenings*

1M
Mammograms*

92.6M
Prescriptions filled

*Data from 2018 National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set.

INNOVATION*

310M
Visits to kp.org

31M
Prescriptions refilled online

6.7M
Members registered on kp.org

184K
Video visits

6M
Online requests for appointments

28M
Secure emails sent

53M
Lab test results viewed online

*Data in this section does not include Kaiser Permanente Washington.

KAISER PERMANENTE: LA CRONICITÀ

Kp considera la buona assistenza ai pazienti con malattie croniche come l'elemento centrale per l'erogazione di un servizio efficace, adottando integralmente il **"Chronic care model"** e investendo in ciò notevoli risorse (personale, sistemi informativi con accurati registri di patologia e sistemi di allerta, programmi di self-management per i pazienti)

CHRONIC DISEASE

GOAL: To improve health and prevent chronic disease in populations with inequitable health outcomes through strategies that create healthy places and policies and empower individuals and families to prevent, manage, and treat their chronic disease(s).

OUR RESPONSE:

- Improve healthy eating and active living opportunities in community and institutional settings through support for community collaboratives, municipal policies, and local programing that helps people treat, manage, and prevent chronic disease.
- Improve the health of students, staff, and teachers in K-12 schools through programs, partnerships, and volunteerism that support healthy eating, active living, and social and emotional wellness.
- Increase community capacity and cohesion of local community networks to advance greater health equity and address chronic disease.

"We bring people together to collaborate, share ideas, and create new opportunities for everyone to live a long, healthy life."

KAISER PERMANENTE: L'ASSISTENZA

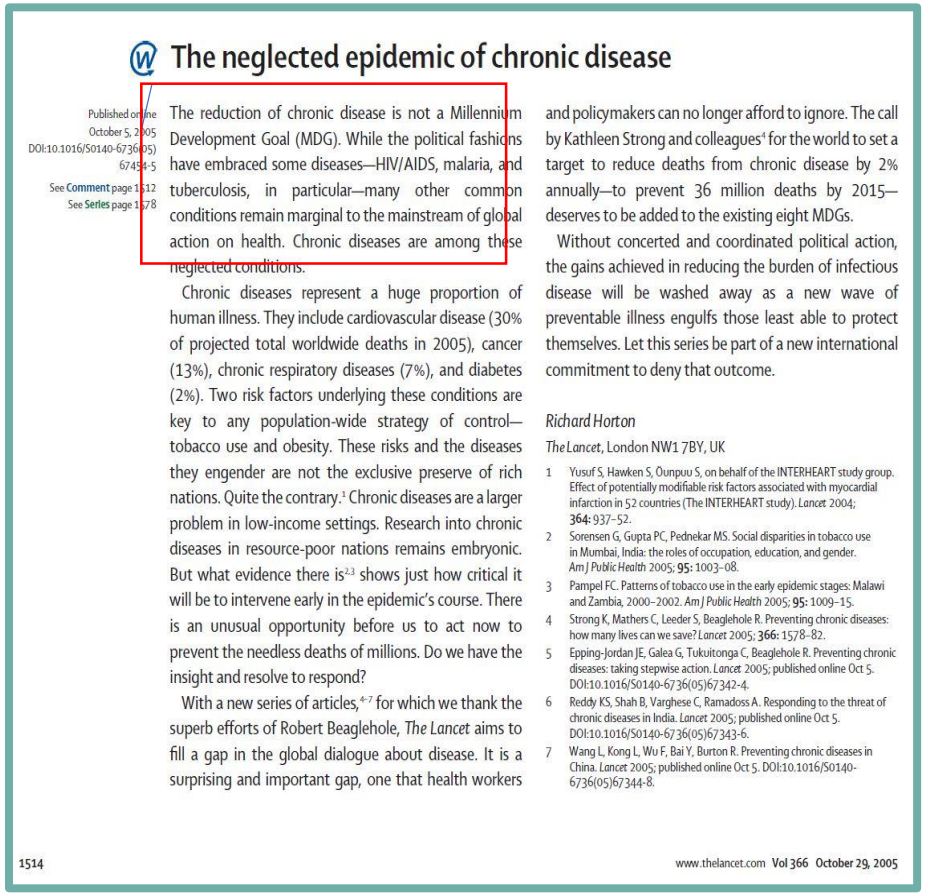
Assistenza su tre step

LIVELLO 3 (Pazienti ad alta complessità: case management)
Quando le persone sviluppano più di una patologia cronica (comorbidità), l'assistenza di cui necessitano diventa di gestione notevolmente complessa per loro, così come per il sistema socio-sanitario. Ciò richiede attività di case management, con un operatore-chiave (spesso un infermiere) che svolga funzione di raccordo delle cure

LIVELLO 2 (Pazienti ad alto rischio: care management)
Disease/care management: team multidisciplinari offrono assistenza di alta qualità basata su parametri Ebm. Si tratta di garantire una gestione delle cure proattiva, protocolli assistenziali concordati e linee guida per la gestione di specifiche patologie. Il sistema deve essere supportato da buoni sistemi informativi: registri dei pazienti, piani di cura, informatizzazione dei dati sanitari

LIVELLO I (70-80% delle patologie croniche: gestione affidata ai pazienti)
Con un sostegno appropriato molti pazienti possono imparare a partecipare attivamente alla gestione delle patologie e a conviverci. Ciò li aiuta a prevenire le complicanze, a rallentare il peggioramento e a scongiurare ulteriori malattie. La maggioranza dei cronici rientra in questa categoria, nella quale piccoli miglioramenti possono produrre un impatto enorme

MALATTIE CRONICHE: EPIDEMIA ANNUNCIATA E TRASCURATA



The neglected epidemic of chronic disease

Published online October 5, 2005
DOI:10.1016/S0140-6736(05)67454-5

See Comment page 1512
See Series page 1578

The reduction of chronic disease is not a Millennium Development Goal (MDG). While the political fashions have embraced some diseases—HIV/AIDS, malaria, and tuberculosis, in particular—many other common conditions remain marginal to the mainstream of global action on health. Chronic diseases are among these neglected conditions.

Chronic diseases represent a huge proportion of human illness. They include cardiovascular disease (30% of projected total worldwide deaths in 2005), cancer (13%), chronic respiratory diseases (7%), and diabetes (2%). Two risk factors underlying these conditions are key to any population-wide strategy of control—tobacco use and obesity. These risks and the diseases they engender are not the exclusive preserve of rich nations. Quite the contrary.[1] Chronic diseases are a larger problem in low-income settings. Research into chronic diseases in resource-poor nations remains embryonic. But what evidence there is[2,3] shows just how critical it will be to intervene early in the epidemic's course. There is an unusual opportunity before us to act now to prevent the needless deaths of millions. Do we have the insight and resolve to respond?

With a new series of articles,[4–7] for which we thank the superb efforts of Robert Beaglehole, *The Lancet* aims to fill a gap in the global dialogue about disease. It is a surprising and important gap, one that health workers and policymakers can no longer afford to ignore. The call by Kathleen Strong and colleagues[4] for the world to set a target to reduce deaths from chronic disease by 2% annually—to prevent 36 million deaths by 2015—deserves to be added to the existing eight MDGs.

Without concerted and coordinated political action, the gains achieved in reducing the burden of infectious disease will be washed away as a new wave of preventable illness engulfs those least able to protect themselves. Let this series be part of a new international commitment to deny that outcome.

Richard Horton
The Lancet, London NW1 7BY, UK

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2 Sorensen G, Gupta PC, Pednekar MS. Social disparities in tobacco use in Mumbai, India: the roles of occupation, education, and gender. *Am J Public Health* 2005; **95:** 1003–08.
3 Pampel FC. Patterns of tobacco use in the early epidemic stages: Malawi and Zambia, 2000–2002. *Am J Public Health* 2005; **95:** 1009–15.
4 Strong K, Mathers C, Leeder S, Beaglehole R. Preventing chronic diseases: how many lives can we save? *Lancet* 2005; **366:** 1578–82.
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6 Reddy KS, Shah B, Varghese C, Ramadoss A. Responding to the threat of chronic diseases in India. *Lancet* 2005; published online Oct 5. DOI:10.1016/S0140-6736(05)67343-6.
7 Wang L, Kong L, Wu F, Bai Y, Burton R. Preventing chronic diseases in China. *Lancet* 2005; published online Oct 5. DOI:10.1016/S0140-6736(05)67344-8.

- **l'evoluzione delle malattie croniche (malattie cardiovascolari, tumori, malattie respiratorie, diabete, ecc.) è sempre stata, storicamente, connessa all'aumento della longevità delle popolazioni**
- **Da almeno tre decenni l'incremento delle malattie croniche è di gran lunga superiore al tasso di crescita della longevità.**

World Health Organization

Director-General

The rise of chronic noncommunicable diseases: an impending disaster

Dr Margaret Chan
Director-General of the World Health Organization

Opening remarks at the WHO Global Forum: Addressing the Challenge of Noncommunicable Diseases
Moscow, Russian Federation
27 April 2011

Excellencies, honourable ministers, distinguished delegates, ladies and gentlemen,

The rise of chronic noncommunicable diseases presents public health with an enormous challenge. For some countries, it is no exaggeration to describe the situation as an impending disaster. I mean a disaster for health, for society, and most of all for national economies.

We must not forget that the same so-called "modernization" that contributes to the rise of these diseases is being accompanied by a growing need for chronic care of mental illness. The burdens are numerous.

I would further suggest that the challenge of combating chronic diseases has some unprecedented dimensions.

LA VERA SFIDA PER QUALSIASI SISTEMA SANITARIO

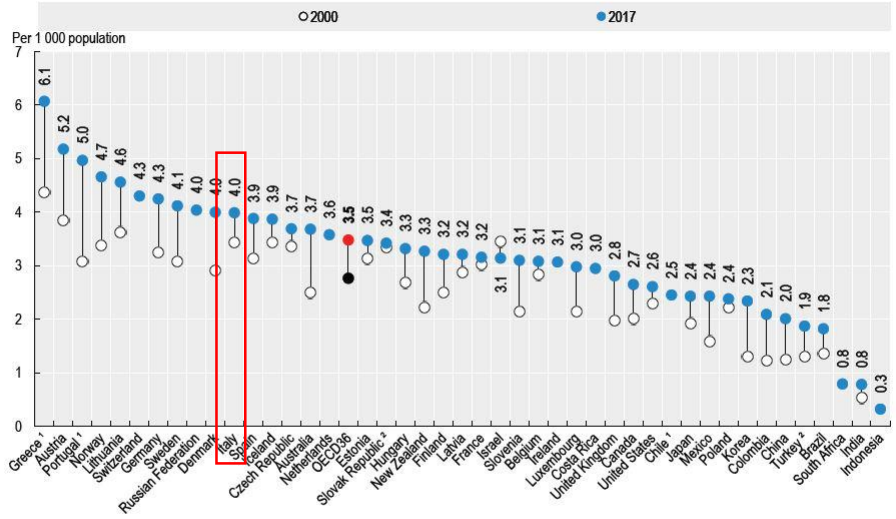
Leggere rapidamente le necessità emergenti e modulare coerentemente le risposte di sistema
Tra queste:

- Formazione delle figure professionali
- Definizione nuovi ruoli e profili di competenze
- Non rinunciare alle opportunità dell'innovazione tecnologica ed organizzativa

WHAT IS TASK SHARING?

Task sharing is envisioned to create a more rational distribution of tasks and responsibilities among cadres of health workers to improve access and cost-effectiveness.

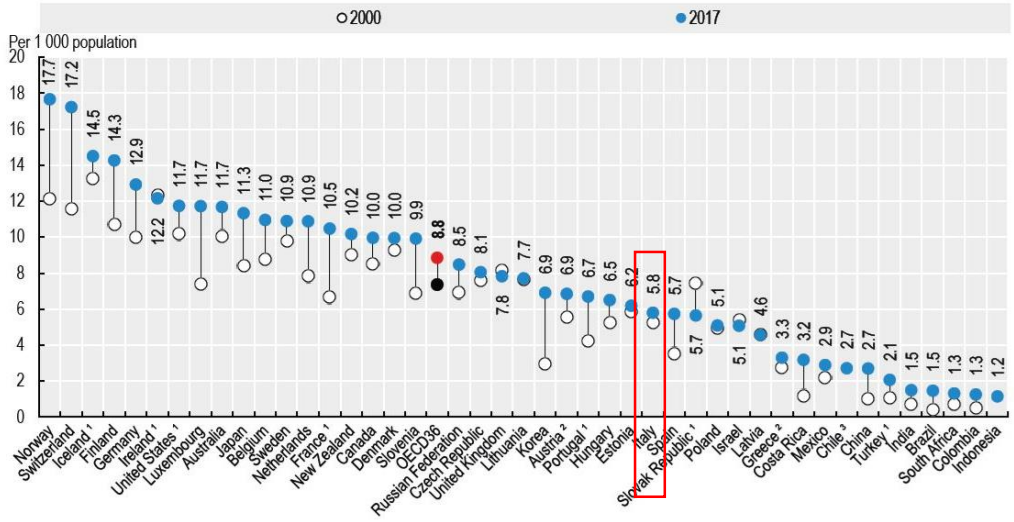
Figure 8.3. **Practising doctors per 1 000 population, 2000 and 2017 (or nearest year)**



1. Data refer to all doctors licensed to practice, resulting in a large over-estimation of the number of practising doctors (e.g. of around 30% in Portugal).
2. Data include not only doctors providing direct care to patients but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).
Source: OECD Health Statistics 2019.

StatLink https://doi.org/10.1787/888934017253

Figure 8.10. **Practising nurses per 1 000 population, 2000 and 2017 (or nearest year)**



1. Data include not only nurses providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. 2. Austria and Greece report only nurses employed in hospital. 3. Data in Chile refer to all nurses who are licensed to practice.
Source: OECD Health Statistics 2019.

StatLink https://doi.org/10.1787/888934017386

LA SANITÀ DEL FUTURO È UNA SFIDA CULTURALE RIVOLTA ALLE PROFESSIONI ED AI PERCORSI DI FORMAZIONE

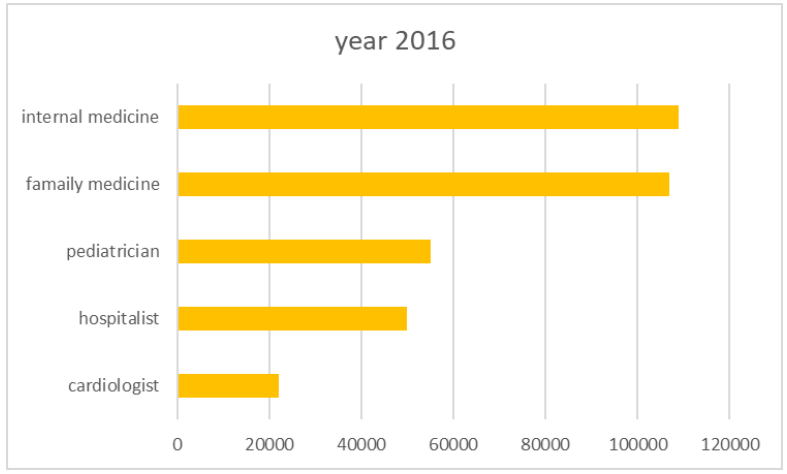
NUOVI PROFILI MEDICI SPECIALISTICI: L'HOSPITALIST

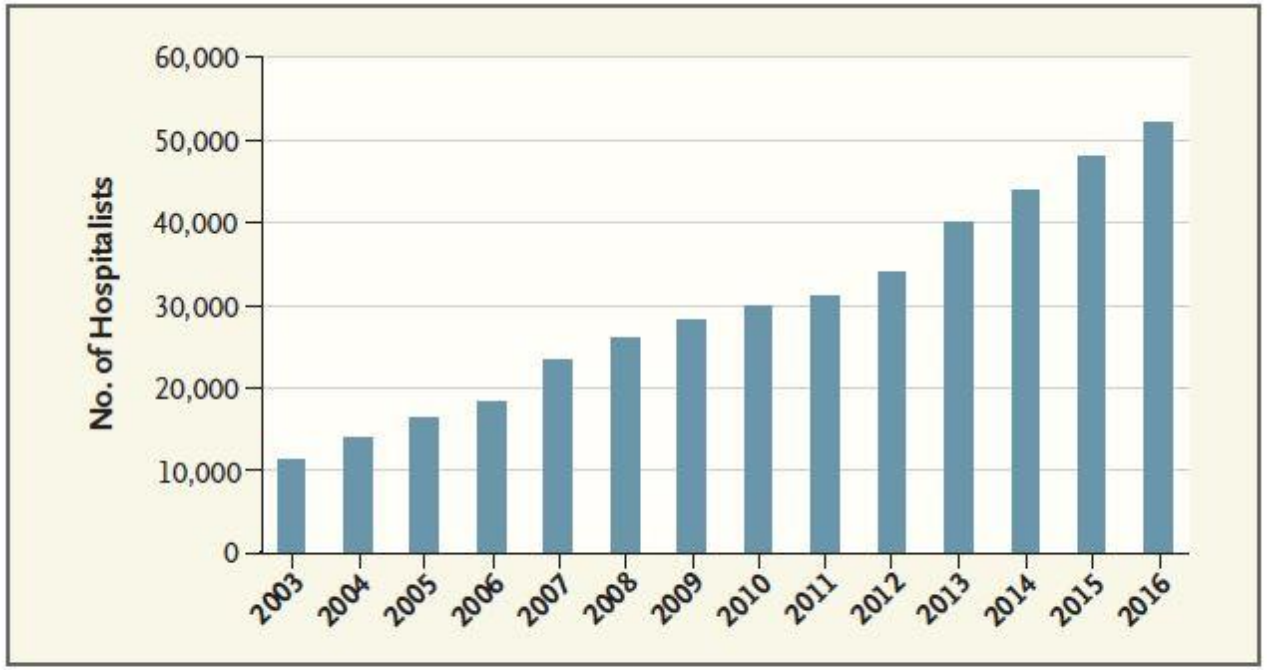
The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Zero to 50,000 — The 20th Anniversary of the Hospitalist

Robert M. Wachter, M.D., and Lee Goldman, M.D., M.P.H.



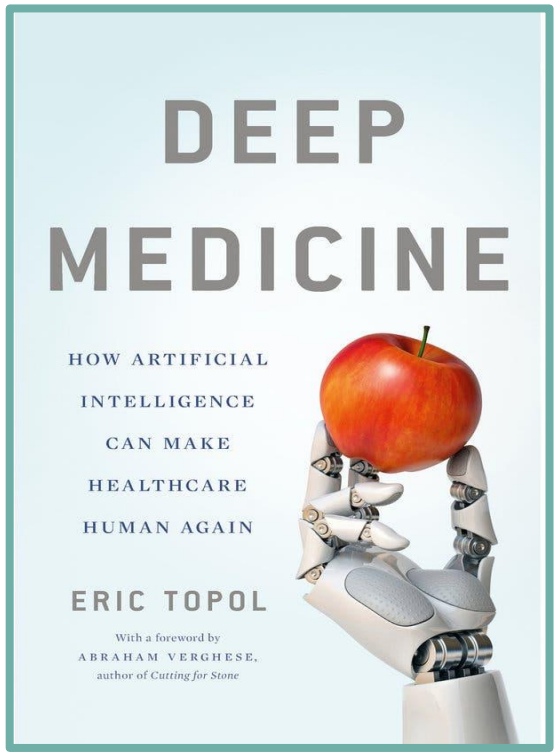


Growth in the Number of Hospitalists in the United States, 2003–2016.

Data are from the annual survey of the American Hospital Association, which began tracking the field in 2003.

Il 75 % di un ospedale USA dispone oggi di medici hospitalist

NUOVE PROFESSIONI, NUOVI RUOLI E NUOVA CULTURA PER AFFRONTARE IL FUTURO



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ORIGINAL ARTICLE ACR 2016

CrossMark

The End of Radiology? Three Threats to the Future Practice of Radiology

Katie Chockley, BA[a], Ezekiel Emanuel, MD, PhD[a]

Abstract

Radiology faces at least three major, potentially fatal, threats. First, as care moves out of the hospital, there will be a decrease in demand for imaging. More care in patients' homes and in other nonhospital settings means fewer medical tests, including imaging. Second, payment reform and, in particular, bundled payments and capitation mean that imaging will become a cost rather than a profit center. These shifts in provider payment will decrease the demand for imaging and disrupt the practice of radiology. Potentially, the ultimate threat to radiology is machine learning. Machine learning will become a powerful force in radiology in the next 5 to 10 years and could end radiology as a thriving specialty.

Key Words: Machine learning, payment reform, technology, future of health care

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ESPERIENZE DI SUCCESSO: KAISER PERMANENTE HMO

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