

FROM THE **ROCKIES**
TO THE **RHONDDA**



Better care for patients and better use of
hospitals – can Wales learn from Colorado?



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THE **WELSH NHS** CONFEDERATION
CONFFEDERASIWN **GIG CYMRU**





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Further information

A document giving more detail about the study tour is available at www.welshconfed.org or www.pfizer.co.uk

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Introduction

The challenges we face and the lessons from elsewhere.

If we are to build twenty-first century health services in Wales, there are two challenges in particular that we have to address:

- 1 **How to ensure that our hospitals are used appropriately and effectively.** They are under unsustainable pressure and are the most expensive part of our health system, costing over £2000 a week for each bed. We need to provide better care for patients in their communities, whether at home or in local health facilities, and use our hospitals for care that can only be given in the sophisticated specialised facilities they provide.
- 2 **How to ensure that the whole NHS is able to meet the needs of patients with chronic health conditions.** Already, patients with such conditions as diabetes, asthma and heart disease are by far the single biggest group of NHS patients; they also account for around 60% of hospital bed-days. The incidence of chronic conditions is set to increase further; indeed, they have been called the 21st century healthcare challenge. This is why we must look for more effective ways of caring for those with chronic illness outside of the already over-stretched and often inappropriate hospital environment.

These are big challenges, but they are not insurmountable. The Welsh NHS Confederation, along with a range of other organisations, recently published a view of how the NHS could look in 2015, called *A Picture of Health*. This picture is of an NHS that succeeded in meeting these challenges, delivering better care for patients in their communities, and making better use of hospitals. These are also key objectives of *Designed For Life*, the 10-year strategy for the NHS recently published by the Welsh Assembly Government. Already in 2005, we are starting to address these challenges, with good work across Wales showing where the future is already happening. But we need to make further progress, and to help us on our way we need to look and learn from success and good practice elsewhere.

With this in mind the Welsh NHS Confederation and Pfizer organised a visit to see the health services offered by Kaiser Permanente, whose effective and innovative approach to long-term conditions has attracted a lot of interest in the UK. We wanted to see, first hand, how they delivered care to their patients, and whether there is anything that can be applied in Wales. In this document, we share our impressions of what we saw, and suggest some lessons that Wales could learn, to ensure that we can develop health services that are truly fit for the twenty-first century.



The Background

Chronic conditions – the twenty-first century health challenge

Chronic conditions are long-term or degenerative conditions which cannot be cured, though they may be treated or controlled. Examples include asthma, diabetes, respiratory disease, arthritis, heart disease, epilepsy and neurological conditions such as Parkinson's disease and multiple sclerosis. The increased incidence of chronic conditions presents an enormous challenge to the NHS. In Britain, 17.5 million adults are living with a chronic condition, which means they are by far the biggest group of NHS patients. Their care consumes a large proportion of health and social care resources.

- 60% of hospital bed days are taken up by patients with chronic conditions and related complications
- In Wales, 38% of the population is recorded as having a long-standing illness, slightly higher than the 35% figure for England
- Up to 80% of GP consultations are related to chronic conditions
- Respiratory illness alone accounts for 28.5% of Welsh patient visits to their GP
- Evidence from the US shows that the care of people with chronic conditions consumes about 78% of all healthcare spending
- Up to 50% of patients with chronic conditions fail to take their medicines properly

The problem is increasing as the population ages and as we get better at preventing premature death from these conditions. More than 75% of over 75 year olds have at least one chronic condition, which is of particular significance in Wales as we have the highest percentage of older people in the UK. The World Health Organisation has said that chronic conditions will be the leading cause of disability by 2020. This is why they have been called "the 21st century healthcare challenge".

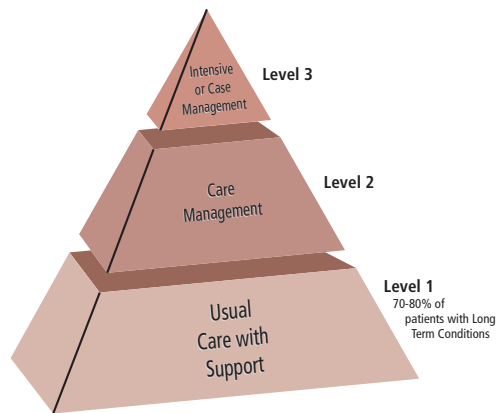
Targeting chronic conditions through disease management and prevention is a key feature of Kaiser Permanente's work.

A disease management approach involves identifying people who either already have an established medical condition, or are at risk of developing one. It is of particular benefit in contributing to the care of people with chronic conditions.

About disease management

The diagram shows the three main approaches used in disease management.

Patients with chronic conditions are stratified according to need, with intensive management targeted at those in the highest risk category.



People at **Level 1 – the majority of patients** – have the condition under reasonable control. This group includes patients who may have a single chronic disease or may be recently diagnosed and have yet to experience any associated complications. Their treatment involves routine assessment of symptoms, reviewing self-management care plans and improving medicines use.

Patients at **Level 2** are those who are having difficulty in managing their condition. They may have multiple conditions, are regular users of primary and secondary care services and are experiencing complications due to their poor management (e.g. a person with diabetes with high blood sugar levels, who is hypertensive, not taking their medicines and not following a healthy lifestyle).

Successfully addressing the needs of these patients will help to prevent them moving into Level 3 and will contribute to reducing new emergency admissions in this group.

Proactive Care Management is the approach applied at Level 2.

This requires decision support systems and involves significant patient self-management and self-monitoring. Care management may also play a part in Level 1 alongside education programmes such as the Expert Patient Programme, smoking cessation services etc.

Patients at Level 3 are those with the most complex needs and are extensive users of health and social care services. This is the highest risk category. The approach used with these patients is **case management**.

This involves a wide range of interventions focused on professional clinical care, with social support, disease education and self-management all playing a part. Although the patients in Level 3 are the smallest group, they require the most resources. However, active management of these high-risk patients is likely to have the biggest impact in reducing repeat hospital admissions.



About Kaiser Permanente

Kaiser Permanente, founded in 1945, is a nonprofit, group practice prepayment programme with headquarters in Oakland, California. Kaiser Permanente serves the healthcare needs of 8 million members in 9 states and the District of Columbia. Today it encompasses:

- the nonprofit Kaiser Foundation Health Plan, Inc
- Kaiser Foundation Hospitals and their subsidiaries (not in Colorado)
- the for-profit Permanente Medical Groups.

Nationwide, Kaiser Permanente includes approximately 140,000 technical, administrative and clerical employees and caregivers, and more than 11,000 physicians representing all specialties. Most members join through their employers, who pay part or all of the monthly dues. Qualified individuals who do not have access to the plan through their employers may also join.

The Kaiser Permanente mission is:

“To provide high quality, affordable healthcare services and to improve the health of our members and the communities we serve.”

Kaiser Permanente in Colorado

This is a partnership between Kaiser Foundation Health Plan and the Colorado Permanente Medical Group, which together provide comprehensive healthcare to KP members. It is Colorado's oldest and largest group-practice healthcare provider, caring for more than 400,000 members in the six-county Denver, Boulder and Longmont metropolitan area and in Colorado Springs. The health plan has more than 4,500 employees and 2004 revenues of \$1.5 billion. KP owns and operates 17 full-service medical offices throughout the Denver/Boulder/Longmont area.

In Colorado, Exempla Healthcare provide acute hospital services to the KP organisation at two hospital sites. KP also use the Memorial Hospital in Colorado Springs. Colorado Permanente Medical Group (CPMG) consists of more than 700 regular-status physicians, representing all medical specialties and major subspecialties, and providing care exclusively for KP members.

The Colorado region of Kaiser Permanente has a strong reputation for excellence and for delivering high-quality services. The region received an Excellent accreditation from the National Committee for Quality Assurance (NCQA), and was listed among the top 10 health plans in the USA in the HEDIS® Effectiveness of Care Measure two years running. This is why the Colorado region of KP was chosen as the focus for the study tour.



What did we see?

We saw much that interested and stimulated us on our visit. The study group were aware of the different cultural background and public service ethos in the USA, compared to Wales, and took this into account when considering what we saw in Colorado. However, our overall impression was that there is much we can learn from Kaiser Permanente, which would have a practical application in dealing with the health challenges we face in Wales. It was also reassuring that much of what we do in Wales compares well with what we saw, and in some cases – such as mental health – our services appear to be of a higher standard or better organised.

ISSUE	WHAT WE SAW
Partnership and teamwork	<p>At the heart of Kaiser Permanente’s (KP) approach is a focus on working in teams made up of different professionals. For example, doctors from primary and secondary care, sharing the same budget, work together in multi-speciality centres that also contain speciality nurses, pharmacists, laboratory technicians, radiology staff and others. Each part of the team has a clearly-defined role to play, according to their specialism, but all work together effectively as a coherent team. The culture of the KP organisation is very different to anything we had experienced before and was based on a “we can achieve anything” attitude. There is a high value placed on recognition and reward of staff. The alignment between the two component parts of the overall Kaiser Permanente organisation is impressive. Each part understands that success cannot be achieved without the other, and that they are truly inter-dependent. Our overall impression is that this is very much a ‘can do’ organisation.</p>
Integration	<p>The most distinctive feature of the KP model is the way in which it integrates care:</p> <p>Integrated inpatient and outpatient care enables patients to move easily between hospitals and the community, or into skilled nursing facilities should this be needed. Medical specialists are not tied to a particular building – such as a hospital – but provide care in the most appropriate setting. Specialists work alongside generalists in multi-speciality medical groups that help communication between physicians. There is no incentive to build up facilities and resources at the expense of other settings.</p> <p>Integrated prevention, diagnosis, treatment and care. A high priority is attached to keeping people healthy and avoiding the use of hospital services. Chronic disease management programmes, where care is delivered within the framework mentioned above, help ensure that care is provided as close to home as possible. Doctors have fast access to diagnostic services in the outpatient setting and practice from relatively large medical centres where diagnostic and other equipment is easily accessible.</p>



ISSUE WHAT WE SAW

Keeping patients out of hospital

The KP philosophy is that for many conditions hospital admissions are an indicator of system failure. In other words, patients are admitted to hospital only when prevention and treatment in the community do not succeed. When patients are admitted, early discharge is made possible by the availability of good intermediate care, in the form of skilled nursing facilities and home healthcare services. Nurses and therapists play a major part in the delivery of intermediate care. Doctors manage patient expectations to enable bed use to be minimised, for example by explaining the benefits of early ambulation and day case treatment. At all stages of care objective measures for moving to the next stage are agreed and tightly managed.

Almost every part of the service uses the telephone to a significant degree, whether it's in providing reassurance when someone is uncertain whether to call upon services, following up discharge with advice, or maintaining patients' ability and motivation to care for themselves.

Their approach to palliative care is another example of how they work with their members to improve the quality of care whilst keeping members out of institutions, which results in high satisfaction ratings, less use of hospitals, but no reduction in length of life.

The overall effect of this approach is that hospitals are used sparingly.

Active management of patients

Patients are actively managed at all stages of their care. Indeed, this happens even before they become patients. When new members join Kaiser, their health status and their potential for needing services are both assessed. This assessment is repeated at regular intervals.

The KP model identifies three levels of care:

- self care support
- assisted care
- intensive management

Following their assessments, patients are classified according to need, demand on services and potential cost. Intensive management is targeted at those in the highest risk category. There are agreed protocols of care for many conditions and settings.

Another example of active management is when patients are admitted to hospital. There is a strong emphasis on minimising stays and maintaining the flow of patients through the hospital. Discharge is planned on or before admission with an emphasis on early rehabilitation, using objective measures to trigger transfers of patients. The aim is to keep patients moving through the system.



ISSUE WHAT WE SAW

Self-care and shared care

Patients are supported to do as much as possible for themselves, and patients, carers and families are regarded as co-providers in healthcare. KP staff seek out and support any efforts by patients to care for themselves, offering advice and support, either in person or by phone or email. Self-care and shared care are particularly important in the management of chronic diseases. Substantial investment is made in patient education and in information to help people with conditions like diabetes and asthma remain independent and healthy. Group consultations involving several patients and a healthcare professional are used to support self-care. Coaching, often by telephone, is a common feature.

Clinical leadership

It was a core view at KP that physician leadership was essential across the organisation, not just in clinical matters. KP creates an effective environment to 'grow' physician leaders. This is seen as a critically important activity based on cultivating and harnessing the core characteristics of doctors as leaders, healers and partners. As a result, doctors and other clinicians are strongly engaged in the management of budgets and services. Permanente Medical Group leaders, and their counterparts in the health plan, understand the pressures and needs of both sides, communicate the 'big picture' to the entire group, and then translate that picture into concrete plans through which the medical group can promote the success of the entire organisation. In practice, this means that leaders working in partnership have to learn to 'fit in one another's shoes,' or to represent each other's interests when one's partner is not in the room. Medical leadership is supported by investment in training and development for those physicians who take on leadership roles. Performance management is rigorous and is based not only on clinical care, but also on teamworking and on patient satisfaction.

Pharmacy

Kaiser Permanente Colorado is noted for the significant involvement of its pharmacists in patient care and their work in the community setting, with pharmacists routinely initiating changes to therapy within tight protocols. The Pharmacy has equal importance and an equal contribution to make, whether in the community or hospital. The use of clinical pharmacists in supporting the work of the organisation and in particular the role of the Pharmacy Call Centre in medicines management is impressive.



ISSUE WHAT WE SAW

Information and technology

The electronic medical record is the key tool which enables KP to deliver care that is patient-centred, safe, equitable, accessible and affordable. All physicians at all facilities have access to a system, which provides a secured single patient record, intranet treatment protocols and real time audit and performance measures. Research has shown that information and IT has helped contribute to a reduction in the use of both primary and specialty services. In addition, the percentage of members with more than three visits a year fell. Telephone contacts, which were rendered more effective by the immediate availability of patient information, have supplanted some outpatient visits.

Transparency of information


There is a very strong relationship between the commissioner and providers, together with a strong sense of enterprise ownership, underpinned by a complete transparency of information. This was particularly powerful in the sharing of financial information. All parts of the organisation shared responsibility for the performance against national quality measures and against regular and comprehensive surveys of member satisfaction.

The KP model in action Aurora Centrepoint Medical Offices

A visit to this centre allowed us to see first hand an example of the key service facility at the heart of the KP approach. The centre covered about 25,000 patients in a 10-mile radius. The 17 physicians were a mix of internists, family doctors and paediatricians. Dedicated administrative staff supported each doctor and there were 8 registered nurses on duty at all times. Each doctor had two treatment rooms where the nurse would fully prepare the patient. The doctors on average saw 20 – 24 patients a day with 20 – 30 minute appointments. The concept of routine rounds of house calls was completely alien to them. They also had a call room staffed by a doctor and nurse who triaged all calls to the centre before making appointments.

The centre had full access on site to simple pathology, radiology and pharmacy. The doctors also had access to advice from specialists either by phone or email.


The partnership between the Health Plan manager and the Physician in Charge was clearly vital. They told us they considered themselves a partnership of equals who were responsible for the delivery of the best care. The level of training and development was impressive.



Intermediate care at the Western Hills Healthcare Centre

This is a Skilled Nursing Facility (SNF) from which KP sub-contracts 35 beds for its members. The unit provides medical and rehabilitative care as well as programmes of entertainment, social activities, and spiritual guidance. Medical input is provided by Permanente physicians. Kaiser Permanente case managers actively manage the care, to ensure patients are getting the right care in the right setting. Rehabilitation services are strong involving a team of qualified physiotherapists, support staff, occupational therapists, speech and language therapists and a dietician, with a rehab manager (Consultant Therapist role) overseeing and coordinating the flow of individuals through the unit.

As well as the SNF, the centre also housed a slow stream and continuing care facility, and KP also has access to 40 continuing care beds in this part of the centre. Relationships between the two parts were good, and patients move between them as needed. There is strong support for the medical staff to help with discharging patients. The clinicians were very complimentary about the social work service, which seems very pro-active and would organise home visits. There are regular multi-disciplinary meetings, which drive discharge planning. Around 70% of discharges are to the patients' own homes. The Assisted Living Care initiative provides customised housing where a high level of dependency care can be given for a limited period of time where required. The average length of stay in this housing for a stroke was about 6 weeks and for orthopaedic discharge about 4 weeks. The overall aim of their approach in intermediate care was to gradually move patients to a lower cost setting.



The verdict - what lessons can we apply in Wales?

We therefore think that lessons from KP that are particularly relevant to Wales are as follows:

Our overall conclusion is that there is much that we can learn from the way in which Kaiser Permanente delivers patient care, to help us meet the twin challenges of providing better care for patients with chronic conditions, and making better use of our hospitals. It is important of course to underline that there are differences between the Welsh context and what we saw in Colorado. Wales is different from Colorado, in terms of issues such as geography, economic prosperity, social values and expectations. Kaiser Permanente is different from the NHS, focusing on a group of members rather than the whole population, and providing a more restricted range of services. Another difference is the way in which the system is funded, through members paying subscriptions rather than by the state through general taxation. These are important differences. But there are more than enough similarities in terms of the issues faced on each side of the Atlantic to mean that we can identify lessons that we could learn.

- Chronic disease management, self-care and shared care should be further developed in Wales to improve the care for people with long standing chronic conditions, help avoid inappropriate use of hospitals and encourage more appropriate use of other services.
- The aim of providing integrated prevention, diagnosis, treatment and care must be at the heart of the changes to our health services in Wales.
- Extended primary and community based healthcare services, offering for example outpatient treatment and simple diagnostics, are the key to keeping people out of hospital and should be developed in Wales to carry out this role.
- The KP models of rehabilitation and intermediate care can be adopted in Wales and should form part of the plans for the development of services.
- Conspicuous and effective leadership is critical in managing change and in delivering and improving healthcare. All healthcare professionals will benefit from leadership development, but at this time of fundamental change in Wales, an emphasis on medical leadership development is particularly important.
- Developing the roles of health professionals – to enable them to reach their full potential – is critical if we are to use scarce skills more effectively and to underpin sustainable services for the future. The role of the pharmacist in the KP model was a clear and important example of how existing roles can be extended. We should emulate this in Wales.
- The use of information and communications technology in the KP model is impressive and the benefits clear. This underlines the importance of implementing Informing Healthcare and the introduction of individual electronic medical records in Wales.
- And finally, we must create, cultivate and harness in health and social care in Wales the culture of shared vision, enterprise, teamwork and partnership that is clear in KP Colorado. This is a powerful force for change, for solidarity and for delivering improvements in patient care.