Testimony of
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Thank you for the invitation to be here today to discuss the role of health information technology in improving health outcomes. I am George C. Halvorson, Chairman and CEO of Kaiser Foundation Health Plan ("Health Plan") and Kaiser Foundation Hospitals ("Hospitals"). Health Plan and Hospitals, together with the contracting Permanente Medical Groups, constitute the Kaiser Permanente Medical Care Program. Kaiser Permanente is the nation's largest private integrated health care delivery system, providing comprehensive health care services to more than 8.7 million members in nine states (California, Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington) and the District of Columbia.

I am sad to say that health care in America is a disorganized, weakly coordinated, inadequately linked, $2.3 trillion care infrastructure[1] that is currently our country's fastest growing industry. It is an industry that will not be reformed without intervention by public policymakers and purchasers.

There is no incentive -- in fact, there is a disincentive -- for providers to adopt more coordinated and efficient approaches to care delivery.[2] Clinicians in America tend to operate in functional silos -- unlinked and unconnected to one another in any systematic, patient-focused way.

More than 75 percent of the health care costs in this country are attributable to patients with chronic conditions[3] -- and more than 80 percent of those costs come from patients with co-morbidities[4] -- patients who have more than one disease. Having more than one disease means having more than one doctor. Those doctors tend not to be linked with one another; most keep their medical information in separate paper

medical records systems. Too often they do not base important treatment decisions on consistent medical science.

Major studies show huge inconsistencies in care delivery across this country. For example, diabetics consume over 32 percent of the total costs of Medicare,[5] and reliable studies show that the U.S. health care infrastructure provides the right care for diabetics less than 10 percent of the time.[6]

What is missing? Why do we spend so much money for such inconsistent and inadequate results? We are missing critical linkages among clinicians and we are missing systematic, patient-focused care.

One key element of the solution is to have vertically linked clinicians functioning in teams to deliver care, supported by a secure electronic medical record (EMR) that gives each clinician the relevant information about each patient in real time at the point of care.

Another key element of the solution is to have special computer systems -- care registries -- that analyze data from the electronic medical record and give doctors and other clinicians reminders and prompts to recommend what the best scientific evidence and expert opinion would agree is necessary and optimal care for each patient.

Only a few places in this country will be able to achieve the full electronic medical record supported by an up-to-date care registry in the immediate future.[7] At Kaiser Permanente, we have made a significant investment in health information technology to provide the tools necessary for providers to deliver optimal care. In 2003, we began the KP HealthConnect™ project, the world's largest civilian deployment of an electronic health record. KP HealthConnect™ is a comprehensive health information system that includes one of the most advanced electronic health records available. It securely connects our 8.7 million members to their health care teams, their personal health information, and the latest medical knowledge, making possible the integrated approaches to health care available at Kaiser Permanente.

In April of this year, we completed implementation in every one of our 421 medical office buildings, ensuring that our 14,000 physicians and all other ambulatory caregivers have access to members' clinical information. In addition, we have completed the deployment of inpatient billing; admission, discharge, and transfer; and scheduling and pharmacy applications in each of our 32 hospitals. Now, we are in the midst of an aggressive deployment schedule of bedside documentation and computerized physician order entry (CPOE). As of today, we have 15 of our 32 hospitals fully deployed and will have 25 completed by the end of the year.

At Kaiser Permanente, we are already realizing the value of health IT. With secure 24/7 access to comprehensive health information, our care teams are able to coordinate care at every point of service – physician's office, laboratory, pharmacy, hospital, on the phone, and even online. Our early results demonstrate that health IT, as the Institute of

Medicine's *Crossing the Quality Chasm* report predicted, helps to make care safe, effective, patient-centered, timely, efficient, and equitable.[8]

To provide a few examples:

- Our use of IT and our comprehensive approach (partnership of primary care providers, cardiologists, nurses and pharmacists with accountability across the continuum of care – preventive, chronic, and acute) have significantly reduced emergency department visits and mortality.

- In Colorado, we've seen a 60 percent reduction in cardiac mortality versus historical KP data. Based on NCQA data as compared to the national HMO average, we prevent more than 280 cardiac events annually in Colorado and realize $2 million in hospital savings.[9]

- In Northern California, Kaiser Permanente patients have a 30 percent lower chance of dying of heart failure than members of the general population. The cost of heart disease and stroke in the United States is estimated at $450 billion in 2008, including direct medical costs and lost productivity from death and disability.[10] Improving the management of just this one chronic condition, we have the opportunity to make a real dent in quality, efficiency and overall spending.

- In Oregon and Washington, using KP HealthConnect™ in a new Regional Telephonic Medicine Center staffed with emergency room physicians and advice nurses, has led to an 11 percent reduction in the number of members who need to visit the emergency room between the hours of 12 noon and 10 p.m.

- In Southern California from 2004 to 2007, combining the power of our IT systems and our integrated delivery model, we were able to

increase mammography screening rates from 80 percent to nearly 90 percent in female members aged 50-69.

This last example was highlighted for me by a recent letter from a member that puts a human face on these statistics.

> Early last year, I came to your facility to have a foreign body removed from my eye. I visited your Ophthalmology Department and your competent staff dealt with this minor emergency.
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> What made this visit so meaningful was my interaction with your nurse after my visit with the doctor. In addition to giving me some after visit instructions, she noticed in the computer that I needed a mammography exam. I had been reminded before but I tend to be too busy to take care of my own health. This time the nurse was very insistent. She even made me an appointment so I could walk in and get the exam within the hour. Since I did not have to wait too long, I had the exam done that day. Well, they found a mass in my right breast and it was cancer. I have gone through chemotherapy and radiation therapy and today I am cancer free.
>
> I am convinced that I am alive today because of your organization's focus on my total health. My interaction with your entire health care system has been nothing but positive. I am especially appreciative to the young nurse who took the time to convince a stubborn old lady to take responsibility for my health.
>
> Thank you for giving me many more years to thrive.

This letter describes a simple act by one of our nurses, but it was possible only because the nurse had access to that information, acted on it, and was part of an integrated health care system that encourages this series of events.

KP HealthConnect™ also allows us to share content across all of our regional facilities, providing the technical platform to provide drug formulary changes, best practice alerts and automated clinical guidelines to the entire enterprise. Our members can move through any facility within a given region and have their clinical and administrative information follow them.

As an example, during the 2007 wildfires in San Diego as Kaiser Permanente facilities within the fire lines were closed, members were contacted and directed to other open facilities. When they arrived, their new care teams had appropriate access to their records via KP HealthConnect™, ensuring continuity of care in the time of crisis.

What Kaiser Permanente and other multi-specialty groups such as Group Health Cooperative, Intermountain Healthcare and Geisinger can accomplish is to set the gold standard with a sophisticated electronic medical record and a fully integrated system. But the rest of the health care system is not vertically integrated and does not have appropriately aligned financial incentives. However, as a country, we can decide to move towards virtual integration and to create payment structures that reward good care, rather than the quantity of services delivered.

Most American patients will need another pathway to computer supported care. That second pathway is possible. We don't need algorithms for hundreds of diseases in order to transform care. We do need algorithms and support systems for the five chronic conditions (congestive heart failure, asthma, diabetes, coronary artery disease, and depression) and for the five percent of the total population who drive 50 percent of the care costs in this country.[11]

If we want care to get better for those patients, we need to insist that all chronic care patients with serious co-morbidities have their care supported by electronic care registries -- and that clinicians who choose not to interact with those registries should be financially affected by their decision.

What happens when care is fully supported by electronic panel support tools? The outcome improvements can be huge. We should set a national goal to decrease hospitalization for asthma patients by 50 percent. We should also reduce congestive heart failure crisis by 50 percent. We should reduce kidney failure by 50 percent.

The electronic medical record alone does not do the work. EMR is a great thing, but an EMR all by itself is not enough. The EMR must be supported by panel management tools that scan the data and give advice to clinicians about needed care.

At Kaiser Permanente, the results of combining those two support tools have exceeded our expectations. A year from now, as we continue to roll our pilot programs out more broadly, I will have another set of outcomes to share.

My advice for you today is this: Our nation's current non-system -- depending on siloed and separate paper medical records and providing perverse financial incentives that directly reward sub-optimal care and discourage efficiency -- will never reform itself. It will also never magically become a "system."

We need to focus on the areas of the greatest potential - and we need to put computerized support systems in place as soon as that work can be done.

Thank you again for the opportunity to be here, and I look forward to your questions.

Endnotes

[1] Centers for Medicare and Medicaid. National Health Expenditure (NHE) "Amounts by Type of Expenditure and Source of Funds: Calendar Years 1965-2017." http://www.cms.hhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet

[2] F.J. Crosson, "The Delivery System Matters," *Health Affairs,* Nov./Dec. 2005; Vol. 24, No. 6: 1543-1548.

[3] U.S Centers for Disease Control and Prevention. "Chronic Disease Overview," Nov. 2005. http://www.cdc.gov/nccdphp/overview.htm#2.

[4] Partnership for Solutions, "Chronic Conditions-Making the Case for Ongoing Care," September 2004 update, Johns Hopkins University. 2004

[5] Centers for Medicare & Medicaid. Medicare Health Support. http://www.cms.hhs.gov/CCIP/

[6] E.A. McGlynn, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine.* 2003; Vol. 348: 2635–2645.

[7] Halvorson G. "Electronic Health Records and the Prospect of Real-Time Evidence Development" Presented at the *Institute of Medicine 2007Annual Meeting: Evidence Based Medicine and the Changing Nature of Healthcare*.

[8] Kaiser Permanente. KP HealthConnect, Value/Quantifiable Benefits. (May 2008).

[9] Ho, PM et al. "Importance of Therapy Intensification and Medication Nonadherence for Blood Pressure Control in Patients With Coronary Disease," *Arch Intern Med*. 2008; 168:271-76; Editorial. "Is Information the Answer for Hypertension Control?" *Arch Intern Med*. 2008; 168:259-60.

[10] Heart Disease and Stroke Statistics – 2008 Update. "A Report of the American Heart Association Statistics Committee and the Stroke Statistics Subcommittee," *Circulation.* 2008;117:e25-e146.

[11] Druss BG. "Comparing the National Economic Burden of Five Chronic Conditions," *Health Affairs*. 2001; 20(6): 233-241.