Institute for Healthcare Improvement

Lessons in Leadership for Improvement

Kaiser Permanente's Improvement Journey Over 10 Years

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How to Cite This Document: *Lessons in Leadership for Improvement: Kaiser Permanente's Improvement Journey Over 10 Years*. Cambridge, Massachusetts: Institute for Healthcare Improvement; April 2016. (Available at ihi.org)

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Background

Over the past decade, Kaiser Permanente (KP) has achieved impressive improvements in quality of care — halving its hospital standardized mortality ratio (HSMR) and reducing hospital-acquired pressure ulcers by more than 80 percent, among other achievements. These accomplishments are all the more remarkable for the size and complexity of the organization in which they occurred: KP is the largest managed care organization in the US, with 175,000 employees serving more than 10 million members across eight states and the District of Columbia. The scale of KP's success reflects, undoubtedly, the ingenuity, talent, and drive of its many employees. But just as essential are the will, curiosity, and determination of its leaders. In so many ways, KP's myriad successful improvements are a testament to what can be accomplished in health care with engaged and effective leadership.

Kaiser Permanente's achievements also owe a great deal to a unique collaboration established 10 years ago with the Institute for Healthcare Improvement (IHI), then and now a leading voice in health care quality improvement. This strategic partnership accelerated improvement at KP, greatly informed IHI's own learning, and helped KP build system-wide capacity for improvement — more than 2,000 trained Improvement Advisors and counting — that may well be without equal in health care.

In the face of tightening budgets and growing demand for accountability, health care organizations are struggling to achieve the needed levels of improvement with piecemeal efforts. Their challenge, then, is to move from improvement as a series of one-off projects to something deeply and seamlessly embedded in the daily work of providing care. This is no easy task, and it certainly has not been so for KP. Many familiar obstacles to improvement efforts — aversion to measurement, resistance to change — have cropped up along the way. Overcoming these obstacles required real culture change, and transforming the culture of an organization as large as KP took leadership of a kind too rarely seen in health care.

Foundations for Change and a New Kind of Partnership

The mid-2000s were a time of tremendous uncertainty for providers and payers in the US: health care spending was increasing rapidly after a slower rate of increase in the 1990s, health care leaders were raising uncomfortable and pressing questions about the quality of care delivered in America, and reform proposals were again beginning to percolate in political circles. Kaiser Permanente's CEO, George Halvorson, concluded that whatever the future held for health care, KP's success — perhaps even its survival — would depend on its ability to improve its way out of any problem. To that end, he had already invested more than $3 billion in a system-wide electronic medical record (KP HealthConnect) to streamline and improve care.

Halvorson's predecessors had also begun building the foundations for system-wide improvement by forming, in partnership with the Permanente Medical Groups, the Care Management Institute (CMI). Formed in 1997, CMI synthesizes clinical practices and disseminates knowledge on the best clinical approaches. CMI leaders also work with regional care delivery teams at KP to implement these best clinical approaches throughout the system to ensure that KP members benefit from the most evidence-based care standards. Both KP HealthConnect and CMI were crucial building blocks

for KP's transformation, but making these investments pay off, Halvorson concluded, would require an organization-wide commitment to innovation in pursuit of higher quality care.

Throughout her career, IHI President and CEO, Maureen Bisognano, consulted with countless health care senior leadership teams and boards of directors. Through these conversations, Bisognano developed four key questions that all leaders in health care need to ask of themselves and their organizations:

1) Do you know how good you are?

2) Do you know where you stand relative to the best?

3) Do you know where the variation exists?

4) Do you know the rate of improvement over time?

The drive to answer these four questions helped leaders at KP build the will for change, create a culture of transparency, and reveal the need for significant innovation.

There was already a nascent understanding at KP that its care, while world class in many ways, was also highly variable — a view supported by data showing substantial differences in the hospital standardized mortality ratio across the Kaiser Permanente system. But despite such evidence, convincing KP's staff to focus on improvement was no easy task, recalls Alide Chase, KP's Senior Vice President for Quality and Service from 2004 through 2014. "As an organization, we had to learn that we weren't as fabulous at everything as local lore had led us to believe," she says. Fortunately, this direction had the backing of both Halvorson and the Kaiser Foundation board.

Kaiser Permanente has a long and proud history of innovation, but Halvorson's vision demanded something more systematic and more deeply ingrained in the organization's DNA. "Kaiser has never lacked for innovation and innovative thinkers," Chase says. The challenge was "making sure we know about them, and figuring out how to conduct evaluations of those innovations and then spread them." To help them do this, in 2005 Kaiser Permanente's leaders turned to IHI.

KP was already very familiar with IHI's work, including its then-ongoing 100,000 Lives Campaign, which sought to improve care and reduce patient harm at thousands of American hospitals through evidence-based interventions in areas such as hospital-acquired infections, adverse drug events, and treatment for acute myocardial infarction. It was at this time that KP and IHI engaged in an unorthodox arrangement between the two organizations: KP created an endowment to fund scholarships for IHI educational programs and trainings for both KP employees and care providers at safety net hospitals. Leaders at KP also set aside funds for the partnership itself, a multi-year arrangement through which IHI would help support and guide internal KP quality strategies.

This was a new form of partnership for both organizations, and KP senior leaders note two features that set it apart from more traditional consulting arrangements. The first, and most important, was that IHI staff did not shy away from giving candid assessments of Kaiser Permanente's existing level of quality of care and potential opportunities for improvement — an approach that was not without its short-term difficulties. "IHI is very good at telling truth to power and ensuring that there is an honest, unfiltered view of the care we provide," said Amy Compton-Phillips, MD, former Chief Quality Officer of The Permanente Federation. "And that kind of honest reflection can be quite challenging to hear. It took a while to say, 'Yeah, we are better than some, maybe better than most even, but we have a lead, not a solution.'"

Paired with IHI's forthrightness was a level of dedication Alide Chase termed "astounding," noting in particular the personal involvement of Maureen Bisognano throughout the 10-year-plus

partnership. "Maureen has been at nearly every performance improvement training we've had," Chase said. "She's so committed. And when our people get to hear from a nationally acclaimed leader in this area, it motivates them in a way few other things could."

Building Momentum

The KP-IHI strategic partnership began with many unique advantages, including KP's resources and leadership commitment, and IHI's expertise in and commitment to improving quality and safety. But the partners also faced a question that has often stymied well-intentioned improvement efforts: How do you build the will to improve throughout the organization and make it part of daily life?

Part of the challenge lay in the delicate task of conveying to hard-working, dedicated employees at Kaiser Permanente that there was still room for improvement in the care being provided — and in answering the first of Bisognano's leadership questions: Do you know how good you are? Early discussions with IHI raised questions about whether KP knew how it was performing with regard to quality, and whether the organization had a sense of the variation in performance among its hospitals (Bisognano's third question). The answer, essentially, was no. One KP senior leader quipped that they were then working in a "data-free zone." As both Socrates and Confucius have explained, real knowledge lies in knowing what you do not know.

The KP leaders tasked with guiding the new improvement efforts swiftly set about remedying that deficiency. In consultation with IHI, Kaiser Permanente assembled a series of high-level quality measures to provide a real-time view of quality across the KP system. The set of measures included hospital standardized morality ratio, Healthcare Effectiveness Data and Information Set (HEDIS) composite, serious reportable events, HCAHPS measures, and other measures that could give KP a picture of their performance in clinical effectiveness, safety, service, equity, and resource stewardship.

Crucially, data for these measures were displayed in real time on an online dashboard, dubbed "Big Q," that was accessible to leaders across the organization — an unprecedented degree of transparency that made variation and subpar performance very difficult to ignore. Creating this kind of transparency, a hallmark of IHI's approach to improvement, exemplifies the profound culture changes needed to achieve ambitious aims. "To have that dashboard showing the actual performance and the variation… that was groundbreaking for us," said Lisa Schilling, Kaiser Permanente's Vice President for National Health Care Performance Improvement. "It was the best first step we could have taken."

Publishing the data for these measures, unsurprisingly, stirred up concerns over risk adjustment and the validity of individual metrics. There was no shortage of pushback, Schilling noted, but IHI's frankness played an important role in propelling KP forward. "A consultant will back off because you tell them to back off," she said. "But a strategic partner like IHI can have the courage to say, 'These metrics are good enough to start, and you need to start.'"

Another improvement fostered by the partnership that helped change the culture at KP was the incorporation of patients' views into improvement initiatives. Bisognano in particular pushed to have each meeting begin with a patient interview, noting that these discussions often revealed remarkable disconnects between provider perceptions and patient realities. During one such interview, Gilbert Salinas, a patient who uses a wheelchair, gave KP executives an unvarnished view of the care they were providing. He recalled the joys of working with his care team, the dedication he witnessed, and the love he felt. But he also told of having to wait weeks for a

replacement tire for his wheelchair. He talked about the recurrent urinary tract infections, some requiring hospitalization, that he contracted due to problems with his catheter. "It was a very powerful moment," Salinas recalled later. "The people [at KP] were so receptive, so forthcoming about wanting to create change, to fix things not only for me but for all patients who had the same problems."

Driving improvement required expertise as well as will. Building capability for improvement is another of IHI's key methods for transformational change, and would become the centerpiece of IHI's 10-year-plus partnership with KP. "We basically glutted IHI's patient safety trainings," said Chase. In the first year of scholarship funding, as many as 30 people from KP attended IHI educational programs, and upon their return they found a fast-growing community of trained Improvement Advisors in their home organization. But if the goal was wholesale transformation, this pace would never be sufficient for an organization as large as KP. "We needed to build IHI trainings into our organization," said Schilling. And that's exactly what they did.

The KP Improvement Institute

Kaiser Permanente launched its Improvement Institute at the company's Oakland, California, headquarters in 2008 to train employees to lead improvement efforts in their home organizations. Creating such a curriculum required regional and national quality leaders at KP to reconcile deeply rooted and divergent approaches to performance improvement. "Different parts of the organization were speaking different quality languages," recalls Bisognano. There were adherents to Six Sigma, Lean, and quality improvement; lacking a common framework, it would be difficult to promote improvement on an organization-wide scale.

KP and IHI leaders sought to overcome this challenge by synthesizing different schools of thought into a unified model for KP — one that took as its core the Model for Improvement and also incorporated elements of Lean and Six Sigma. This approach illustrates two additional leadership lessons: the importance of context and the dangers of dogmatism.

No two organizations are exactly alike. Indeed in health care, no two hospitals or clinics are exactly alike, and in many instances, no two units within the same facility are exactly alike. A successful improvement in one area does not guarantee, or sometimes even predict, success in another. Only by carefully considering the specific contexts of the organizations, facilities, or units one is aiming to improve, will one find success.

In KP's case, the context of previous knowledge and application of various improvement methodologies was an essential input in designing how the Improvement Institute would conduct its work. IHI's years of experience in improvement have also taught another lesson — that dogmatically adhering to one improvement method is counterproductive in a context in which many have had positive experiences with other methods. Finding the middle ground for the KP Improvement Institute's approach to performance improvement was an important condition for the success of the KP-IHI partnership.

KP's leadership wanted to embed improvement knowledge at all levels of the organization, from frontline staff to senior executives. The Improvement Institute began by focusing on staff working on the front lines of care, aided by a fruitful partnership with the unions representing KP employees. The bigger hurdle was enlisting clinical leaders to try out performance improvement within their regions. The importance of starting small was another lesson IHI had learned over the years and sought to impart to KP's leaders. "We needed to find a few key leaders who were willing to try and fail because it wasn't going to be a home run right out of the gate," Schilling said. "We

cashed in a lot of chips to do it, and we found a few medical centers in regions that were willing to try."

These improvement leaders spent a year traveling to health care organizations renowned for their quality performance — places like Cincinnati Children's, Intermountain Healthcare, and the Geisinger Health System — to learn from best practices. These site visits also enabled KP leaders to answer Bisognano's second leadership question: Do you know where you stand relative to the best? Guided by this vanguard of curious and committed KP leaders, employees at all levels of the organization began collaborating to build driver diagrams for high-level aims to guide improvement efforts (see Figure 1).

Figure 1. Example Driver Diagram for High-Level Aims

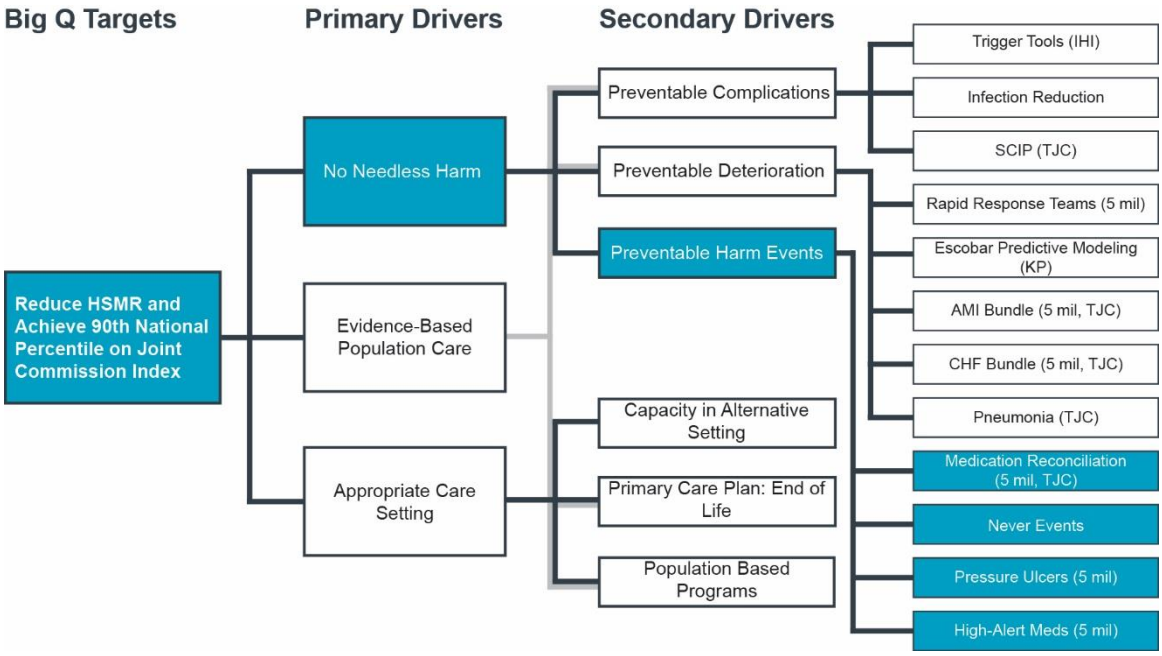


Figure note: "TJC" is The Joint Commission; "5 mil" is IHI's 5 Million Lives Campaign

By the end of the Improvement Institute's first year, enough progress had been made that one regional president committed to making performance improvement a top priority by establishing a performance improvement director at every medical center in the region, while also training hundreds of employees in KP's method of performance improvement. Momentum built from there, and today KP has trained more than 2,000 Improvement Advisors in house. A recent training program had 350 spots, all of which were filled with nearly 100 more wait-listed.

This internal training program can seem rather prosaic compared to the actual work of improvement, but without it, KP would never have been able to achieve improvement on such an impressive scale. "In many organizations, leaders often assume that the folks working directly with patients understand and already know how to 'do' improvement," says Bisognano. "A lot of times, the importance of building improvement capability in staff is overlooked. That didn't happen at KP."

Reducing Sepsis Rates

Early on, the Big Q dashboard measures highlighted a troubling deficiency at KP. As of 2007, KP hospitals exhibited significant variation in standardized mortality ratio, and the system as a whole was underperforming the Medicare average. This data clashed strongly with internal perceptions of KP's quality of care. To help interpret the data, IHI invited Sir Brian Jarman, a leader in health care quality and the creator of the hospital standardized mortality ratio (HSMR) methodology, to speak with KP's regional leaders. These sessions had a tremendous influence on how many of the regional senior leaders viewed quality. Importantly, KP's quality leaders avoided ultimatums, instead seeking to convince regional leaders — with Jarman's help — that the data showed the need for improvement.

During one of these sessions, leaders in one KP region took up the challenge posed by this lackluster mortality data. Using methods learned from IHI, the region conducted a comprehensive review of the last 50 inpatient deaths at each of 19 medical centers in their jurisdiction. They found that sepsis caused nearly a quarter of inpatient deaths, even as only 3 percent of patients had sepsis as a primary or secondary diagnosis.[1] Sepsis is a scourge of inpatient wards around the world, killing in excess of 30 percent of sufferers even in advanced hospitals.[2] But ample evidence shows that this mortality rate can be cut by between 8 and 56 percent through early identification, rapid antibiotics administration, and therapy aimed at ensuring hemodynamic stability.

These three prongs of treatment sound deceptively simple. In 2007, emergency department staff at KP, as at most health care facilities across the US, did not routinely screen for sepsis. When they did identify a septic patient, delays in ICU admission meant urgent, life-saving interventions were often held up for several hours. And the workflow from ED to ICU did not support a seamless handoff of a patient undergoing treatment to maintain hemodynamic stability.

Following the mortality review, the region hosted a summit in May 2008 that was attended by hundreds of employees dedicated to reducing inpatient mortality. The inpatient death chart review identified several recurring themes, and suboptimal sepsis care clearly played a substantial role in the high mortality rates. Multidisciplinary teams at two KP hospitals were tasked with piloting sepsis screening tools, treatment algorithms, and staff education strategies.

In fashioning a new system of care to enable optimal treatment for sepsis, KP was able to draw on the three-year-old Surviving Sepsis Campaign, which promulgated guidelines for reducing sepsis mortality around the world. And as they tested the sepsis guidelines in clinical settings, KP relied heavily on Plan-Do-Study-Act (PDSA) cycles and the Model for Improvement, developed by IHI's long-time collaborators, Associates in Process Improvement (API). After many rapid PDSA cycles and resulting modifications, the teams organized their best practices into a sepsis "playbook," which they presented at a sepsis-specific regional summit in November 2008.

The success of KP's sepsis identification and reduction project relied on the full support of clinical and operational leaders within the region; the backing of the region's chair of emergency department chiefs proved particularly crucial, as much of the work of sepsis screening and treatment fell to ED physicians and staff. In the ensuing months, each medical center in the region commissioned a team to implement the sepsis processes in the playbook, train staff, and monitor improvement over time. Project leads discussed progress and pitfalls during monthly conference calls and, importantly, could pilot changes to the original protocols to fit their care environment. The regional leadership supported this endeavor in myriad ways, purchasing at least one hemodynamic monitor for each ED and ICU, convening annual sepsis summits, launching a

monthly sepsis newsletter, and creating an intranet site with access to relevant tools, journal articles, and performance data.

By 2011, the number of sepsis diagnoses had more than tripled, making clear just how many had been missed before the use of a standardized screening tool. And the hospitals weren't just diagnosing better — the proportion of septic patients who received antibiotics within an hour of diagnosis climbed 20 percentage points; the percentage who met all elements of the early goal-directed therapy bundle jumped from 7 percent to 61 percent; and the proportion of septic patients who showed a reduction in lactate levels within six hours of diagnosis rose by 40 percentage points. IHI helped disseminate KP's successful sepsis guidelines to other organizations.

Spreading Innovations: The Nurse Knowledge Exchange

Even before KP embarked on its partnership with IHI, it had been working to overhaul transfer of information during nursing shift changes. At KP, as at health care organizations across the country, shift changes presented opportunities for error and miscommunication to occur. When consultants from the design firm IDEO asked KP providers which processes or workflows they found most challenging, nursing shift change was the clear winner.

In 2004, KP convened a group of 40 nurses and nurse assistants to develop ideas for improving this system. What emerged from those discussions became known as Nurse Knowledge Exchange (NKE), a process for nursing shift changes in which the on-coming and off-going nurses conducted handoff discussions at the bedside with a portable computer, thus allowing the patient to participate. The system also called for use of whiteboards in patient rooms to list patient care goals and upcoming procedures. In addition, NKE incorporated a database called NEURON to create automated shift change reports to streamline information transfer between nurses.

Having tested this model at four KP sites, its designers now faced a different challenge: How could they rapidly spread this new way of doing things throughout the vast Kaiser Permanente system? Senior IHI leaders had long been studying this difficult step in improvement and were able to advise KP on developing a support structure to manage the rollout across disparate inpatient sites. IHI counseled use of an exponential spread technique — that is, instead of introducing NKE to hospital units one by one, it was rolled out at several initial units, each of which was then tasked with training three additional units. Those units would each train another three units, until the program was fully implemented in a given hospital. IHI, in turn, drew on the success of this approach to distill best practices into a white paper about spreading innovation.[3]

Reducing Medication Errors

Another issue KP focused on early in the partnership with IHI was medication administration, driven by research estimating that medication errors occur as often as once per patient per day in American hospitals.[4] In 2007, a KP team led by Christi Zuber and Chris McCarthy, who had recently completed IHI's 10-month Improvement Advisor program, began interviewing nurses about medication administration as well as observing them in real time. They found a process plagued by interruptions — an average of 1.5 to 2 interruptions per medication administration — that was both demoralizing for health care workers and dangerous for patients. In response to these findings, KP's Innovation Consultancy, an internal design consultancy and a collaboration

with the design firm IDEO, assembled a group of 70 designers, nurses, doctors, pharmacists, and patients to propose changes to the medication administration process.

Of the 400 ideas proposed during a two-day conference, one very simple one caught the conveners' attention: a large bib with a sign reading "LEAVE ME ALONE," for nurses to wear while administering medication. A prototype, without capital lettering, was soon piloted in KP hospitals. This simple intervention, dubbed "no-interruption wear," went through countless PDSA cycles, changing from a safety vest to a fat sash to a slimmer garment that could be easily folded up and carried in a pocket. Another intervention in the no-interruption mold was the creation of a clearly marked "sacred zone," which no other caregiver would be allowed to enter while a nurse was using it for medication administration.

These changes, in combination with use of a barcoding scanner for electronic medical record (EMR) documentation and medication verification, among other elements, formed the basis for KP MedRite, a package of changes that Kaiser Permanente sought to roll out to as many of its hospitals as possible. A crucial part of this effort to spread KP MedRite was the creation of a "change package," a set of materials that explains the intervention and gives frontline clinicians the tools to adapt these changes to their local environment. IHI learned from KP's success in implementing MedRite and has since posted the MedRite change packages on its own website as an example of best practices in spreading innovations.[5] This is but one of many instances in which IHI reaped significant benefits from its partnership with KP and endeavored to spread the learning beyond KP.

Since KP MedRite's roll-out, interruptions have fallen 50 percent, while the proportion of nurses who consider the medication administration process clear, safe, and easy has risen from 68 percent to 90 percent. There are five basic steps to medication administration: comparing the medication with the medication administration record, checking two forms of patient identification, explaining the medications to the patient, opening the blister packs in front of patient, and immediately charting the medications administered. Before implementation of KP MedRite, all five of these check steps were completed only one third of the time; after KP MedRite, this figure rose to nearly 80 percent.

As KP added more and more trained Improvement Advisors to its ranks, such improvement initiatives proliferated. For example, a KP team in Northern Colorado discovered that only 43 percent of its adolescent asthma patients prescribed an inhaled corticosteroid were refilling that medication. By proactively contacting patients or their parents, developing talking points to emphasize the importance of this controller medication, and encouraging use of the mail-order pharmacy, the Northern Colorado region raised the refill rate to 60 percent in just nine months. In the Mid-Atlantic region, an improvement team managed to increase the percentage of hypertension sufferers whose blood pressure was under control from 62 to 72 percent in one year.

Lessons Learned

Kaiser Permanente has been able to achieve impressive results. When Alide Chase retired from KP after nearly 10 years of managing the KP-IHI partnership, her colleagues in analytics presented her with a gift that conveyed just how far the organization had come with her leadership. It was a framed picture of the hospital standardized mortality ratio (HSMR) across the KP system from 2008 through 2012, showing that HSMR had fallen by 52 percent over four years.

Not long after, at its December 2013 meeting, IHI's Board of Directors invited Chase and her colleague, Dr. Jed Weissberg (who was also retiring, as Executive Vice President and CMO of

Kaiser Foundation Hospitals and Kaiser Foundation Health Plan), to reflect on 10 years of partnership with IHI. Chase and Weissberg showed the same graph depicting the reduction in HSMR since 2008, in addition to other graphs documenting a decrease in inpatient bed use and increases in member satisfaction for both hospitals and ambulatory care settings. They went on to describe parallel improvements in bloodstream infection rates, C. difficile rates, serious reportable adverse events, hospital-acquired pressure ulcer rates, readmissions, and worker injury rates. And in a moment of extreme generosity, Chase and Weissberg credited the partnership with IHI for making these gains possible.

The improvements made by Kaiser Permanente in the past 10 years illuminate the power of collaboration in health care improvement. No one organization knows it all, and every organization benefits from learning from others. From the will-building leadership questions posed by Bisognano, to the culture-changing transparency of the Big Q dashboard, to the transformative capability building of the Improvement Institute, to the life-saving improvements in sepsis care and medication management, the history of KP and IHI's strategic partnership is defined by mutual benefit.

The Future

In the past 10 years, there has been a sea change in health care. While everyone in the industry has long known that the purpose of improving health care delivery is to improve health, only recently has there been widespread acknowledgement that the impact of care delivery improvements on health is relatively small. Individual behavior and, crucially, the social determinants of health play a far larger role in creating and sustaining health. Kaiser Permanente has helped lead this acknowledgment in the industry. Beginning in 2004, around the same time as the formation of its partnership with IHI, KP developed an innovative public messaging/advertising campaign called Thrive. Its messages were clear — creating health for its members through proactive strategies is just as important to KP as how it delivers care to its members when they get sick.

Ten years on, the KP-IHI partnership has also evolved to focus on health creation. In 2007, IHI first articulated the Triple Aim — simultaneously improving the patient experience of care, improving the health of populations, and lowering the per capita cost of care — as the paramount goal for health care systems. And in the fall of 2014 the 100 Million Healthier Lives initiative was launched, an unprecedented coalition of leaders committed to supporting 100 million people living healthier lives by 2020 by convening some of the most forward-thinking and committed leaders in the US — representing health care, community health, public health, employers, policymakers, funders, patients, and community members — to work together to achieve this ambitious goal.

In 2014 IHI also launched the Leadership Alliance, an initiative for health care system executives and their teams to work toward two ambitious goals: delivering high-quality health care today, and developing new health care models for tomorrow. Leaders from Kaiser Permanente, notably Chase, have played an active role in the Alliance from its inception. In addition to participating in the steering committee, KP has also brought leaders from across the organization to participate in and lead several of the Alliance's design teams, each focused on meeting key challenges in health care delivery systems today.

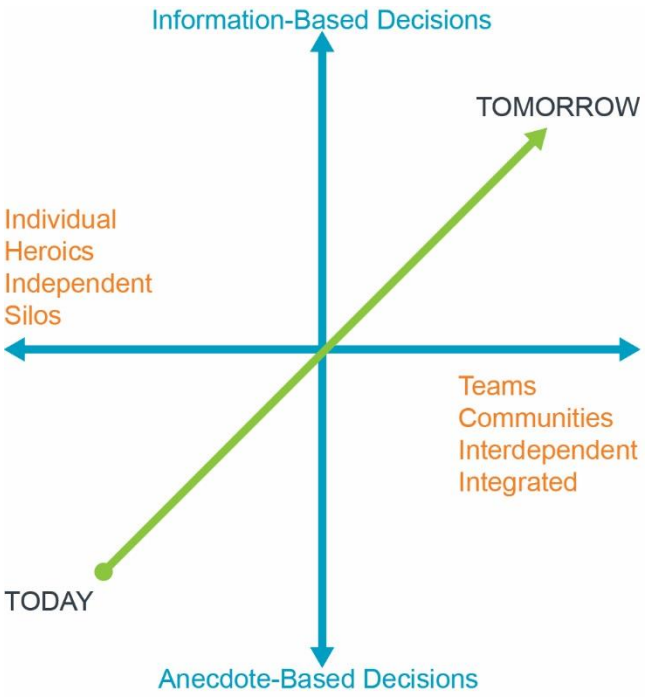
Meanwhile, KP has sought to move care into the community, both to improve health and to lower the costs its members pay. KP's Total Health approach starts with addressing the well-being of the whole person — spirit, mind, and body — and seeks to bring together both clinical and community assets to address all the determinants of population health. Examples of KP's Total Health initiatives include workforce wellness, increasing physical activity and access to healthy foods in

schools, and connecting people to resources in the community that help meet their non-medical and social needs. "Our challenge as a partnership is to push the envelope with regard to the Triple Aim and health equity," said Julia Taylor, a Director at IHI, who worked on the collaboration with KP for more than 10 years. "Both organizations know we have to go in that direction."

The partnership between IHI and Kaiser Permanente continues to grow and strengthen, with the work now focused on new challenges and under new leadership at both organizations. Derek Feeley, who became President and CEO of IHI in January 2016 following Maureen Bisognano's retirement, continues to provide guidance to the partnership and a new generation of leaders at KP is propelling the newest work forward. Bernard Tyson succeeded George Halvorson as Chairman and CEO in 2014, and Patrick Courneya, MD, and Patricia Harvey, RN, have succeeded Weissberg and Chase. These leaders have enthusiastically embraced the challenges of the new (and still rapidly changing) health care landscape, and have just as enthusiastically embraced their predecessors' appreciation for collaboration. And despite the significant changes in leadership, there has been no lull in activity, and no decrease in knowledge creation or impact.

Kaiser Permanente is embracing an interdependent approach to knowledge creation and leadership (see Figure 2). "Sharing collective expertise and leveraging knowledge and experience within and outside our organization will help us meet our growing member and patient expectations," says Harvey, Senior Vice President for Medicare Clinical Operations and Population Care.

Figure 2. Interdependence at Kaiser Permanente



As it embraces interdependence across the entire organization, Kaiser Permanente now seeks to ensure that best practices in care and service from seven regions spanning eight states and the District of Columbia are available to every member, wherever he or she is located. Existing processes effectively spread best practices within and across regions and functions, but an initiative called "One KP" takes spread to the next level. Kaiser Permanente aims to provide a seamless experience of excellent care and service for members that is not bound by geographic

location — and, increasingly, innovative care delivery methods, such as telehealth and virtual visits, provide excellent care anywhere members carry mobile devices.

Similarly, Kaiser Permanente is applying all that it has learned about quality improvement in medical care to the behavioral health needs of members. "Although we have much to be proud of in the work we've done during our relationship with IHI," says Courneya, Executive Vice President and Chief Medical Officer, Kaiser Foundation Health Plan and Hospitals, "history also tells us that the opportunity to work toward achieving the Triple Aim is limitless." Improving population health and sustainably reducing costs are aims arguably much more difficult to achieve than providing quality care within hospital walls. Each is determined by myriad influences, most of them traditionally considered beyond the reach of health care. But after a decade of partnership, confidence abounds at both organizations.

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