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Profiles in Leadership

Ben Chu helps Kaiser Permanente make quality count

Benjamin Chu, MD, MPH, MACP, oversees Kaiser Permanente Southern California and Hawaii as group president. In the seven years since he arrived, Kaiser Permanente has amassed many awards for quality. He also is chairman-elect of the American Hospital Association and will begin serving in that capacity in 2013. Prior to joining Kaiser, he was president of New York City's Health and Hospitals Corp., the largest public health system in the country. He also served as associate dean at both Columbia University and New York University.

Following is an edited transcript of the conversation:

You have a Bachelor's degree in Psychology. What spurred you to go for an M.D.?

I think I always was going to be a doctor. Unlike a lot of people who have a core basic science orientation, I was always more interested in the human side of medicine. Psychology, child development, and anthropology are more in line with things I was thinking about. As you know, in medicine, there are a lot of behavioral and developmental aspects. In order to be effective, you have to understand the cultural determinants of health. All of these factors led me to pursue work in a field where I could actually help people. There is a whole sociology and culture of medicine that one cannot fully understand unless viewed from the psychological perspective.

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You spent most of your life out East before moving to California. What spurred that move, and has it worked out as you expected?

I was running the NYC public hospital system under Mayor Bloomberg. It was an incredible experience and an incredible job. We were doing very innovative things in that system. It is a huge system that cares for 1.3 million NYC residents. When the opportunity arose to move to California and run a large chunk of Kaiser Permanente, the prospect piqued my interest. How far can you take a systems approach to delivering on improving the health of the population under the care of a large system? In Southern California, Kaiser Permanente has 3.6 million members, three times the size of the population we were caring for in NYC. The nice part about it is that the components and pieces are linked in a large multi-physician group that only works with the health plan and the hospitals. The health plan allows for pre-payment for care of the population. There is an entire delivery system under us that allows us to decide how to parcel resources in order to achieve the goal of maximizing the health of the population we serve.

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How do you get a big system like KP to deliver on its promise and to take healthcare to a whole different level?

That was both the challenge and the fun part of coming to KP & California. I didn't know many people when I was coming to Kaiser – primarily George Halvorson [chairman and CEO] and Ray Baxter [senior vice president for Community Benefit, Research and Health Policy]. It's been an incredibly rewarding experience. We had to put systems in place — our electronic health record and other systems — to allow us to look at our performance in a very open, honest, and critical way. We had to reconfigure the system. KP had been better than average on quality and outcome for our members. Now, because of what we've been able to do with tools, reconfiguring our system, and getting complete alignment of our systems, components and people (including the 60,000 employees in Southern California), we are pretty close to leading the country on many metrics.

From Leapfrog to NCQA, KP across the board has achieved some remarkable ratings for quality.

There has been a steady progression over the last half dozen years. We've taken a systematic approach. We engaged every member of our staff, from doctors to non-doctors and from professionals to frontline workers, to get to that point. It has been very rewarding and a lot of fun to do.

The last six years coincide with your arrival. What role did you play in these changes? What role did you leadership team play? What did you look for when bringing a new leader on board?

To tell you the truth, I don't think I have brought anyone new in, believe it or not. I spent time getting to know the people here. We have a wonderful leadership group, and there have been very few changes. The changes were largely to replace people who left. What would be the key to our success? It hovers around getting complete alignment over what we wanted to do.

Much of the alignment was around trying to make sure we did everything possible to benefit our members. It was not a financial decision. While financials are important, they aren't driving our goals at this point. The larger point was to make sure everyone understood that at the end of the day, it is our members and patients, and how we perform for them, both in the individual aspect and aggregate aspect.

People rallied to this message of reaching for the higher mission. It's hokey to think about in that way, but you'd be surprised. Everyone comes into healthcare to make a difference in another person's life. One of the things we did as a leadership team was to galvanize everyone's desire to make a difference and reminded people of this. I think this is the key to leadership overall. I am blessed to have a lot of incredible people working with me on much of this.

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Obviously we had to put in the systems to give us the information to know if we were making a difference in people's lives. Once we got that in place and held that mirror up, the ideas came flowing out, and we could tap into this wellspring of creativity and desire to do the right thing. I am a doctor by training in a non-clinician role right now, but it is a pleasure to see that marriage of clinical outcomes and my public health background on population health outcomes come together in a delivery system.

As you look at your role at the American Hospital Association as chairman-elect beginning in 2013, do you get the sense that part of what they are looking to you for is to help other hospitals across country pick up on what Kaiser has done and get the quality scores up and make a difference nationally?

If you actually talk to the hospital leaders and members of the boards across the country, there is an enormous amount of energy working to find ways of taking care of their communities. Part of this is the quality agenda. Thousands of hospitals have joined the hospital engagement networks that are forming right now and are trying to learn from each other and optimize the quality of care given in the hospitals themselves. Hospitals are beginning to see that they play a pivotal role in their communities.

Rather than be passive and wait for people to get sick and come in, there is a role to be played more upstream – to make a difference in the community's fabric and in its health. Some of it has a lot to do with impacting the developing ACOs. It is an often misunderstood, yet often used, term. The idea is to get an organization and care delivery system to care for a population and try to go as upstream as possible to find strategies that lead to good health and mitigate things that lead to bad health, not just treat emergency situations. It means partnership with providers who work in the upstream levels. Doctors who see patients in an outpatient setting tied to the hospital or in their practices – we need to link the two together.

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There is a lot of energy in the hospital world. One of the reasons I was asked to chair in 2013 is that there are tremendous, yet uncertain, changes that are happening. There are also these powerful positive forces that can help hospitals and health systems come together in a better way to take better care of their communities. I think I was asked to chair so we can engage in a system-wide and country-wide dialogue to help each other overall.

Given the uncertainty around reform — does that make leadership harder for you and the people running hospitals round the country?

It depends on what you mean by harder. It certainly makes it much more interesting. The pathways to choose are much more ambiguous. In uncertain times, leadership needs to focus energy on the right things. I think that is why the AHA is working with our member hospitals to determine the higher-order outcome. If we dive into the weeds and get into the arcana of legislation and stay there, we will get lost. That is not to say reimbursement and policy changes aren't important, but if that is all we think about, there is no ability to guide organizations through a field of uncertainty.

If you can't pick up your head to see where you are going, you cannot mobilize physicians and institutions to move in the same direction, and we will be mired in the field and will not get anywhere. That is the difference between someone who is good operationally and a leader who can engage people in dialogue to get everyone to a place where we want to be.

There seems to be a growing consensus among healthcare leaders that we are on a course of change that will continue whether mandated or not.

I think that is absolutely correct. Healthcare is changing in a good way, I think. I know people worry about losing the good things in uncertain times. When you think about what we are capable of doing and how many people we are capable of doing things for,

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I am convinced that with a little change in perspective and focus, we can utilize the dollars we spend in healthcare and create a lot more healthy communities. It is a journey in a lot of ways — a very uncertain journey. I think the focus is changing. Payment reform is happening. A lot more transparency is coming. There will be changes to tell us how we are really doing. Once you are confronted with that information, it is a compelling force driving changes that could get us to a better place.

There seems to be an increasing interest in physician executive leadership. As a doctor and physician yourself, what is your take on that?

The lesson we've all learned is that in order to take on the larger tasks, the triple aim, all of the key pieces must be aligned. Physicians and other healthcare professionals have to be integrated into the whole system. We are trained to be separate. Even though hospitals are a part of the action where people are treated and where doctors do what they do, they are still only a piece of the puzzle. To integrate the perspectives, many places are looking towards physician leadership, whether as an administrator or at a Medical Director/CMO level. We need voices there and to be open and honest about the larger goal. We cannot just see hospitals as a doctor's workshop. That will only get us so far. Obviously, we want someone to care for patients and bring their expertise. However, it is not just a single doctor, but multiple healthcare professionals. We want to see the larger role for the community.

We need to make decisions on the deployment of resources and make a bigger difference than just delivering the best care in the ER. I'm not saying the best care shouldn't be delivered in the ER, but when you think about it, it may not be the optimum expenditure of resources if you only concentrate on the ER.

In my opinion, there should be more doctors at senior levels of health systems. Having everyone's perspective is important and makes a difference.

Healthcare organizations, particular in the inner cities, are creating senior housing, opening banking centers, farmers' markets, and developing other innovative systems and ideas such as free surgery day. Is this part of the equation at Kaiser Permanente as well?

At Kaiser, we have a theater troupe that goes into grade schools to do thousands of performances on healthy eating to influence kids on eating habits. Every one of KP's medical centers runs a farmers market. In fact, we run the only farmers market in Los Angeles. This is illustrative of what I was talking about earlier — the tremendous amount of energy spent in the hospital world trying to figure out how we go upstream. The medical model is individual — one person at a time. When someone is sick, you care for them and send them back out. This is an important function for every community. The underlying premise is that the sum of all the good one-on-one work will translate into a healthier community. Clearly, this model leaves huge gaps. The medical model really is not directly focused on the population's and the community's total health.

There is a broader understanding that what makes a person healthy or not is as much about the health of the community and total health of the environment as it is to prescribing the right medicine. Eighty percent of the determinants of health are not linked to care. Smoking, exercise, drug use — these are things people need to think about if we are going to make a greater impact on the community and population health.

Collectively, if 5,000 hospitals and health systems can get it together and start moving upstream together, it could be a very powerful force. **FG**

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