



## Northeast Division Affiliation with Community Health Plan, A Staff Model HMO

***This article explains the necessity for the Northeast Division to affiliate with a major established HMO in order to become a true regional player in the Northeast. It describes what the focus has been to integrate the Northeast Permanente Medical Group and the Community Health Plan staff model clinicians and how the process is progressing.***

It is an honor and a pleasure to write the first Medical Directors Report in the new *Permanente Journal*. I am particularly grateful for the opportunity to tell our story because what has happened here in the Northeast during the last year is critical as Kaiser Permanente faces two significant challenges: successfully affiliating with other organizations and growing through more diverse, network-based delivery systems. Those of us in Permanente Medical Groups, and in the newly formed Permanente Federation, must learn how to manage quality in network-based delivery systems and create and nurture new Permanente Medical Groups.

As 1996 began, the Northeast Region of Kaiser Permanente served 116,000 members in 13 health centers in Western Massachusetts; Hartford and Stamford, Connecticut; and White Plains, New York. The Region had been created by the successive acquisition of three pre-existing HMOs over a period of 14 years. Northeast Permanente Medical Group (NPMG) consisted of 120 physicians and a like number of associate practitioners who were divided into three distinct local Medical Groups, each with its own Board of Directors and its own Medical Director. The three groups were led by an Executive Medical Director, Simi Lyss MD, accountable to an over-arching Board, the Northeast Permanente Management Corporation. This Board, in concert with Dr. Lyss and the three Area Medical Directors, was responsible for ensuring consistency of clinical practice and Group management throughout the Region.

The Northeast Region was not dominant in any of its markets except the relatively rural Western Massachusetts. Although net income had been positive for the previous six years and the Region had attained a positive net worth and very good quality and service performance, membership in its health centers had been flat for several years. There was, however, encouraging growth in newly formed networks in all three of our areas.

Both Program and Regional leaders had realized for some time that success for the Northeast Region depended on our becoming a larger, truly regional player in the greater Northeast. It was unlikely that we could do so without completing a major affilia-

tion with an established partner.

When we first began speaking with Community Health Plan (CHP) in 1996, it was a 19-year-old, not-for-profit plan, well known and respected in its several markets: Vermont, Eastern and Central New York State, and Western Massachusetts, where it competed actively with Kaiser Permanente. CHP had been founded as a staff model and still served 180,000 of its 400,000 members in 41 health centers, many of which were small medical offices with two to four physicians in rural areas of the Northeast. Several years earlier, the Plan had responded to insistent requests by major customers to expand choice by creating affiliated networks. In the following 15 years, the organization expanded its affiliated network to include more than 6,500 physicians and established several joint ventures with integrated delivery systems, such as the Bassett System in Cooperstown, New York.

CHP, too, aspired to be a major player in the Northeast. Despite impressive membership growth and delivery system diversification, their leaders concluded that the Plan would need to affiliate with a larger, preferably national organization to thrive over the long term. They entered into discussions with several potential partners, including Kaiser Permanente. The commonalities of history, mission, and culture made it clear in the spring of 1996 that an affiliation of CHP and KPNE would benefit both organizations and create a formidable new organization in the Northeast. On April 12, at a press conference in Albany, the two organizations announced their intention to affiliate, pending regulatory approval. On July 22, CHP became a subsidiary corporation of Kaiser Foundation Health Plan.

From our earliest meetings together, the clinical leaders of the two organizations—Bruce Nash, MD, CHP Medical Director; John Charde, MD, Associate Medical Director for Quality Management; Simi Lyss, MD; and I (Associate Medical Director at that time) agreed that the most effective way to integrate NPMG and the CHP staff model clinicians would be to focus on common clinical management. From the beginning, we shared our quality and resource management plans and programs and began to learn from and help each other. Over the last nine months, for example, NPMG and CHP clinicians have worked closely to create a group of common clinical guidelines and a unified 1997 QRM workplan for the entire Division.

Structural, formal integration of the two groups of clinicians, however, has been a more complex matter without precedent in the history of Kaiser Permanente. At the time of the affiliation, leaders of CHP believed that CHP staff model clinicians should have

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STACY D. LUNDIN, MD was Group Medical Director of the Northeast Permanente Medical Group (NPMG) of Massachusetts from 1987 to 1993. He became the NPMG Associate Medical Director in 1993 and was named NPMG Executive Medical Director in July 1996.





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the right to choose their future, whether to join NPMG, form a separate medical group, or some other choice. Furthermore, NPMG's Board of Directors had decided, before the affiliation with CHP, that our Medical Group needed to re-evaluate our governance and management structures as well as our financial relationship to Health Plan. We had decided to engage consultants from American Practice Management (APM) and Dr. Marc Bard, who had worked with us for a number of years. Marc and Carl Mankowitz MD, a partner from APM in Manhattan, had worked together to help Harvard Community Health Plan's staff model evolve toward self-governance, and we believed that their experience would be valuable to us.

Discussions about this work with CHP leaders resulted in a joint effort that began in November, following a weekend retreat in the Catskills, where NPMG and CHP clinicians met to learn more about each other and tentatively explore how we might most effectively work together.

Two parallel work groups were formed, one for NPMG and one for CHP. Although NPMG's pre-existing board structure provided a basis to constitute our group, CHP clinicians faced the dilemma of how to create a workgroup with legitimate authority, since they had no prior governance structure. A general election involving all their staff model clinicians resulted in the choice of 14 people representing the various clinical disciplines and geographic areas within CHP.

The two workgroups, facilitated by the consultants, labored in parallel for approximately ten weeks. The NPMG group focused on creating an aspiration that would enhance its performance and address the complexities of the new Division, including the relationship with Health Plan and the CHP clinicians. Meanwhile, the CHP workgroup focused primarily on the form of their future structure; they considered a number of options, including becoming a Permanente Medical Group.

When it became clear that the directions of the two groups were converging, the CHP workgroup expressed keen interest in learning more details about NPMG and Permanente Medical Groups in general. Several members of the NPMG workgroup and I met with the CHP workgroup and tried to convey the essence of what it means to be a Permanente physician or associate practitioner. We were honest with our colleagues: we stressed that NPMG faces significant challenges and that those of us in the Group must learn to embrace change, even when the change is painful. We talked about accountability and ownership. We stressed the value of self-governance and self-management and the unique partnership that we enjoy with our Health Plan colleagues. And most important, we emphasized that our strongest commit-

ment is to finding better ways to deliver care and service that is affordable to our members. Al Weiland, MD, the Northwest Permanente Medical Director, came to speak with the CHP workgroup about the value of belonging to a Permanente Medical Group, the significance of the new Federation, and the range of new capabilities that would be developed through PermCo.

In March the two workgroups joined in a series of day-long meetings in the Berkshire Hills of Western Massachusetts. Those discussions between the CHP and NPMG workgroups proved to be extremely productive. Over a brief period of several weeks, the group of 20 or so people faced difficult problems, talked them through, showed a remarkable capacity to compromise creatively, and ultimately produced a set of recommendations supporting the formation of a common Permanente Medical Group in the Northeast. That Medical Group will likely consist of six local groups, each with its own Board of Directors, to accommodate both the state laws in the Northeast and the geographical size of the Division. Those six groups will be held together by the Northeast Permanente Management Corporation and its President, the Executive Medical Director. The completed recommendations, which address issues such as shareholder status, Board composition, Group leadership, and the role of associate practitioners, will be presented in April to the CHP clinicians for ratification and to the NPMG Board of Directors for approval.

During the last year the Northeast Division has been on the exciting and uncomfortable “cutting edge” of integration in Kaiser Permanente. We have learned a number of lessons that can be useful to the Permanente Medical Groups and to the Health Plan as they strive together to become the national leader in health care:

- Clinically focused integration is an effective way to bring together groups of clinicians; concerns about improving clinical care provide common ground and are a natural bond for people who take care of patients.
- Even in organizations with apparently similar cultures and traditions, the differences that inevitably exist cannot be underestimated but instead need to be recognized and respected. It simply isn't adequate to say, “we're so much alike that we will obviously agree.” When true differences are acknowledged as soon as possible, it is more likely that they will be successfully confronted and overcome.
- Relationships are more likely to succeed when people enter them freely and with enthusiasm. A forced union of CHP clinicians and NPMG earlier in the process would not have worked.
- We in the PMGs have much to be proud of but also much to learn. Our CHP colleagues, for ex-



ample, have extensive experience in developing and managing affiliated networks and joint ventures. That experience can prove invaluable not only to us in the Northeast but to other Permanente Medical Groups throughout the country.

- We had to constantly remind ourselves that our real goal was not integration for its own sake, but the improvement of performance in all areas. Coming together was a means to an end, not an end itself.

This has been a difficult year, and many of us asked ourselves from time to time, "would we do it again if we knew what we know now?" The answer, even with all the problems we have faced and still do face, is a clear and strong "Yes!" The rationale for the affiliation of CHP and Kaiser Permanente Northeast

is as compelling now as it was a year ago, and there is already good evidence that our new Medical Group and our new Division can capitalize upon the experience and knowledge of each organization to produce a powerful competitor in the northeastern United States. The kinds of challenges we have faced in the last year are the kinds of challenges that Kaiser Permanente will necessarily deal with as it seeks to grow to 15 million members in the next five years. The management of diverse delivery systems, and the management of "new relationships" will have to be core competencies for us. That work has begun already in the Northeast, and I am proud to have been a part of it. ❖

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"Cultural schizophrenia: The modern condition born of a disconnection between attitudes and behaviors, between the world as it is presented and the world as we intuit it to be. Cultural schizophrenia occurs whenever society begins to reinvent its vision of how it will conduct affairs in the future."

*Watts Wacker, Wired, June 1997.*