Quality improvement –
Evaluation & Innovation
at Kaiser Permanente’s Program Office

Jim Bellows, PhD
Director, Center for Evaluation & Innovation

Carol Cain, PhD
Principal Consultant, Incubation

Estee Neuwirth, PhD
Senior Manager, Evaluation & Innovation

KP Care Management Institute
June 23, 2009
Talk outline:

Our team: R&D at KP

Case study #1: Complex Chronic Conditions
  Background on KP and informatics

Case study #2: Panel management

Case study #3: Transitions in Care
CMI’s Mission and Principles

CMI works with its Regional partners to build a superior integrated care delivery system for KP members

• Keeping patients at the center
• Harnessing technology
• Integrating capabilities across KP
• Applying evidence
• Measuring results
• Spreading successful practices

CEI Mission

CMI’s Center for Evaluation and Innovation (CEI) supports performance improvement across KP by providing performance metrics, identifying success factors, evaluating impact, and supporting innovation
CMI Organizational Structure

Co-Executive Directors
Scott Young, M.D. and Carolyn Mustille, RNP, MSN

Community Benefit

Management & Administrative Support

Communications

Center for Health Care Delivery and Center for Health Care Analytics

Center for Evaluation and Innovation

Updated: MAY2009
CMI Portfolio

- Initiatives
  - Palliative Care
  - Complete Care for Complex Conditions
  - Transitions in Care
  - Cardiovascular Disease

- Region-specific projects

- Services
  - Knowledge Services
  - Clinical Library
  - Network maintenance – Implementation, Analytic, etc.
Our Mission
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- Keeping patients at the center
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- Spreading successful practices

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cmi.kp.org

Center for Evaluation and Innovation
Jim Bellows, PhD, Director
Eric Tom, Manager - Analytics
Sybil Songhian, Operations Specialist
Christopher Jentz, Program Evaluation
Gregory Nah, Program Evaluation
Estee Neuwith, PhD, Program Evaluation
Maggie Wang, PhD, Program Evaluation
Carol Cain, PhD, Incubation
Erin Dirks, Analytics
Jennifer Kallenbach, Analytics
Lori McGilchrist, Analytics

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Our staff

- 12 FTEs

- By education
  - 4 PhD
  - 7 Masters-level (2 ABD)

- By training
  - 3 Health services research
  - 1 Sociology
  - 1 Biomedical informatics
  - 2 Statistics
  - + Public policy, public administration, business

- By work area
  - 5 Analytics
  - 3 Quantitative evaluation
  - 1 Qualitative evaluation (+ contract support as needed)
  - 1 Innovation support and incubation
Our team

KP Care Management Institute’s Center for Evaluation & Innovation

[care management institute]
Talk outline:

Our team: R&D at KP
Case study #1: Complex Chronic Conditions
  Background on KP and informatics
Case study #2: Panel management
Case study #3: Transitions in Care
Program evaluation reveals variations in implementation

<table>
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<th>Key Components</th>
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Key: dark = robust; light = mechanism in place; N/A = not part of program objectives
Evaluation at each stage is focused on supporting further spread

For example:
What does the early majority want to learn from early adopters?

- Typical evaluation of pilots focuses mainly on impact
- Potential adopters have other questions
  - Does the innovation work once it is transferred, or was its initial promise mainly due to specific factors at the innovation site?
  - How will the innovation affect our patients? Our staff? Our costs? Our roles and relationships?
  - Which version seems to work best?
  - What site-specific factors are important?
### Case study #1: Home monitoring for Complex Chronic Conditions

#### Test, Patient

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**Kaiser Permanente thrive**

[Image of healthcare technology]
America’s Largest Non-Profit Health Care Program

- Integrated health care delivery system
- 8.7 million members
- 14,000 physicians
- 160,000 employees including 41,000 nurses
- 8 regions in 9 states and D.C.
- 32 hospitals and medical centers
- 421 medical offices
- $38 billion operating revenue (2007)
Kaiser Permanente has made a multibillion dollar investment in KP HealthConnect, a secure nationwide electronic data system that is:

- More than just an electronic record
- A highly sophisticated information management and delivery system
- A programwide system that integrates the clinical record with appointments, registration, and billing
- A complete health care business system that will enhance the quality of patient care
Clinical decision support: SmartSets

Opened Sub-Section

Individual Order within a Sub-Section
Clinical decision support:
Best Practice Alerts

Best Practice Alerts
Pop-up that alerts clinicians to patient safety or health maintenance reminders, utilization reminders, and quality reminders.
SmartText Used in Patient Instructions

**SmartText (ETX)** Text block that can include SmartLinks and SmartLists, and can be restricted by age/gender. Multiple Types (such as Progress Notes, Letter, Patient Instructions).
This page displays basic information about your recent visits. If you need more information please contact your Kaiser Permanente facility. If you have any questions about the information on this page, please call 1-800-123-4557.

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CDS Infrastructure: Groupers

**Groupers (VCG)**

Grouper master file that defines groups of other master files; for example, over 200 EDG terms for asthma can be placed into one VCG record.
KPHealthConnect is one of many IT Systems
Talk outline:

Our team: R&D at KP

Case study #1: Complex Chronic Conditions
Background on KP and informatics

Case study #2: Panel management

Case study #3: Transitions in Care
Culture change: PCP responsibility for patients who do not present

**Total Panel Ownership**

An overall approach to delivering care, based on “Advanced Medical Home”

- Accountability & Incentives
- “Know your panel”
- Access

**Panel Care Management**

- Panel support staff
- Work flow
- IT “Panel Support Tool”

**Panel Management:** Specific tools and processes for finding and closing “care gaps”
Kaiser Permanente uses evidence-based guidelines, registries, and team-based population care for patients with chronic conditions, such as:

- Asthma (2.7% of members)
- Cardiovascular artery disease (3.4%)
- Chronic pain (5.1%)
- Depression (7.1%)
- Diabetes (9.3%)
- Heart failure (1.4%)
- Obesity (30% of adults)
PHASE:
Proven preventive therapies

4 Drug Interventions

- **Antithrombotic medication**
  - Treatment with aspirin 81-325 mg daily unless contraindicated
  - If contraindicated, use of clopidogrel is recommended

- **Lipid-lowering medications**
  - Treatment with statin is recommended even if LDL-C is <100 mg/dL

- **ACE inhibitors**
  - Treatment with ACE inhibitor long-term unless contraindicated

- **Beta blockers**
  - Treatment with a beta blocker for members with CAD, PAD, and AAA unless contraindicated

Controlling 3 risk factors

- **Blood pressure**
- **Lipids**
  - Statin dose sufficient to bring LDL-C levels < 100 mg/dL
- **Blood glucose control**
  - HgA1c < 7.0 is optimal for members with diabetes

4 Lifestyle Changes

- **Tobacco Cessation**
- **Physical Activity**
- **Healthy Eating**
  - Recommend a diet rich in fruits, vegetables, legumes, nuts, whole grains, and n-3 polyunsaturated fat
- **Weight Management**
  - Weight management reduces multiple risk factors
People
- Dedicated PCP time
- Support staff (MA, RN), protected time

Process
- Identifying patients with care gaps and conducting outreach

IT Tool
- Internally developed, linked to electronic data sources

Panel Management process

Generate list of patients, by care gaps

Prepare clinical data summaries

Review patient status, decide on treatment

Execute orders, communicate

RN or other licensed staff – clinic-based or centralized

Primary Care MD

Clinic-based staff
Early signs of success

Diabetes - Blood Pressure Control

Pilot site launches Panel Management

% of members with diabetes with BP <130/80

- Highest facility
- Pilot site
- Region average
- Lowest facility

**Previous Model**

Key Features of Model:
- Physician care primarily reactive – visit based and responsive
- Limited capacity for risk stratification or proactive care management interventions
- Care management program siloed (more or less) from primary care team with ancillary staff “offloading” physician
- Minimal communication and coordination between physician and care manager

**Panel Management**

Key Features of Model:
- Physician and team proactive, accountable for clinical outcomes and patient satisfaction
- Systematized process for coordinating physician and panel management team activities
- Increased capacity & options for chronic care, leveraging physician time and ancillary staff support to extend physician
- Sophisticated I.T. infrastructure supporting population-level chronic care
Population care gaps

**Therapy Gaps**

- **Asthma**
  - Consider start/increase of inhaled steroids
- **Heart Protection**
  - Heart Protection (Statins, ACE-I, Aspirin) for High Risk Populations
- **Statins**
  - CVD & DM populations
  - Based on 10yr CAD risk score
- **ACE/ARB**
  - CVD risk (HOPE and EUROPA trials)
  - DM Nephropathy
  - Heart Failure
- **Aspirin**
  - Daily Aspirin for High Risk Populations
  - Based on 10yr CAD risk score
- **Beta blockers for**
  - Post-MI
  - Heart Failure
- **Glycemic control**
  - Insulin consideration when A1c > 9 and on Orals > 1yr
  - Metformin consideration when BMI > 27 and A1c > 8
- **BP control - Consider adding BP meds when BP > 140/90**
- **Osteoporosis**
  - Women 65+ with T-score <= -2.5
  - Post-fracture - osteoporosis per HEDIS

**Monitoring Gaps**

- **Chronic Condition - Monitoring**
  - DM
    - HbA1c screening due
    - Renal screening due
    - Eye screen due
    - Foot screen due
  - High Risk Populations
    - LDL screening for high risk populations due
  - CKD
    - Lab(s) due - Creatinine, microAlb/Cr or UPr/Cr, Hgb, Lyles

**Prevention Gaps**

- **Primary Prevention**
  - High Risk Populations
    - Flu shot due (during flu season)
    - Pneumovax due
  - General Population
    - Mamo due
    - Pap smear due
    - Colorectal screening due
    - Cholesterol screening due q 5yrs
    - Tetanus shot due
    - Osteoporosis screening due
A focus on health promotion

Preventive Health Prompt (PHP) printed at every visit to track preventive services. A shared tool with copy to patient and to clinician. Includes due dates for:

- Mammogram
- Sigmoidoscopy
- Pap smear
- Immunizations
- Cholesterol check
- Routine physical
- Pneumonia vaccine, etc.
Whole-panel views – vital signs for the primary care team

Intermediate Outcome

* LDL < 100 (CVD & DM)

Therapy

** Statin Use (CVD & DM)

Print % CVD and DM pts with LDL LT 100

Click Here to see All Intermediate Outcomes Graphs

Chronic Condition Monitoring

*** HBA1c Testing w/in 12 mos

Primary Prevention

**** Mammography
Rapid Region-wide improvement after full transition to panel management

<table>
<thead>
<tr>
<th>HEDIS Measure Effectiveness of Care</th>
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<td>81.4%</td>
<td>87.1%</td>
<td>84.5%</td>
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Panel management – Qualitative results

- Patients like it – they appreciate the outreach and reminders
  - “When someone reminds you of your health, it’s really important, and I really appreciate it.”

- PCPs feel more effective… but still feel crunched for time
  “Panel management doesn’t make my day any easier, but it makes my day better.”

- A surprise on staffing: The PMA role may be better suited to unlicensed medical assistants than to registered nurses
  - The PMA role can feel like a broadening of role for a medical assistant, but a restricted role for an RN
  - Physicians tend to lean on RNs to make routine clinical recommendations, but…
    “It sounded like the nurse and the doctor were not talking to each other. I don’t want the nurse knowing something that the doctor doesn’t know.”

http://xnet.kp.org/permanentejournal/SUM07/panel-management.html
Talk outline:

Our team: R&D at KP

Case study #1: Complex Chronic Conditions
  Background on KP and informatics

Case study #2: Panel management

Case study #3: Transitions in Care
Patient-centered transitions design

CMI & Innovation Consultancy

May - Jun

Observations

Laying the foundation

Aug 4-5

Deep Dive

Storytelling

Imagining the possibilities

Brainstorming

Field testing

Synthesis

Dec -

Refining

Dec +

Piloting & learning

Building the future

http://ideabook.kp.org/groups/pt-transitions
2008 methodology breakthrough: Video ethnography
Storytelling: “My blood pressure is lower than your blood pressure”

- One way Dr. Kuyawe tries to keep his patients out of the hospital is by using the panel support tool.
- He actually shows patients how they rate compared to other patients.
- “Everyone wants to be competitive,” he explains.
- He may show a patient their blood pressure on a graph and point out that it is the highest of his whole panel.
- No one wants this distinction so they will actually work harder to lower their blood pressure, for the end goal of coming back and seeing how they’ve moved lower on the graph.
### Findings | The Patient Perspective

<table>
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<th>Findings</th>
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<tr>
<td>Patients focus on and value other things, not the transition itself:</td>
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<td>- they are concerned about their condition and “getting well”, “going home” and “getting back to normal”</td>
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<td>- their hospitalization is an interruption of their normal life—it’s an “artificial” setting</td>
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<tr>
<td>“One foot out the door”</td>
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<td>- On the day of discharge, patients are emotionally focused on going home and are not capable of efficiently absorbing information</td>
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<td>The discharge process is often a “bad ending”</td>
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<td>- lengthy and unpredictable time span</td>
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<td>- poor coordination between hospital floor and pharmacy</td>
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<td>Only after they get home and start to experience their recovery do patients really recognize and understand they face barriers to optimal recovery</td>
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<td>- care information that is skimpy or hard to understand and interpret in relation to their individual circumstances</td>
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<td>- complex medication regimes</td>
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<td>- re-contacting the right person or department at Kaiser</td>
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<tr>
<td>Caregivers play a far larger role in managing “transition” and recovery than seems to be recognized by providers</td>
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Brainstorming & Enacting: tools, roles, space, and processes
Field testing in West LA
CONCEPT

An online listing of patient care and home needs.

Halted Idea - ELECTRONIC REGISTRY FOR PATIENT NEEDS

Caregivers are often overwhelmed and overtaxed with all of the patient care needs. Friends and family can sign up for these activities in order to help spread the responsibilities of the patient & caregiver’s needs among many people.
Transitions in Care
Care Management Institute (CMI) 2008 Initiative: From hospital to home

The Deep Dive
July 21st, 2008

We have completed the observations, shared stories and learning with all of you in the regional sites, and now it is time for West Los Angeles, Colorado and Hawaii to come together for a 2-day activity we call a "Deep Dive."

Observers are invited to the first morning of the Deep Dive, August 5th from 8:30-10:15 am.

During the Deep Dive you will:

1. Hear the themes of our patient centered observations
2. Share our decision to breakthrough care we have made
3. Hear from our stakeholders on where we are heading
4. Focus on our next steps to make breakthrough change
What’s distinctive about our approach?

• Partnership among improvement, innovation, and evaluation
  – Evaluation not arms-length, but with sufficient independence
• Relevance and timeliness
• Patient focus
  – Voices of Our Members
Questions?

IF YOU CAN’T TAKE IT WITH YOU
STAY LONGER.
Thank you!
KP Care Management Institute

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