



Population Management for Chronic Conditions

Warren Taylor, MD
Medical Director, Chronic Conditions Management
Kaiser Permanente Northern California

September 26, 2005



KPNC's Strategy:

Northern California will use our integrated, not-for-profit model of health care to deliver superior quality and service at a competitive price

Relationships, Service, Reliability

The 5 (or is it 7) P's

- **Performance** – match the performance of the best
- **Personalization** – increased focus on first-time and infrequent utilizer
- **Physician and People Excellence** – attract and retain excellent staff who provide superior quality and service
- **Prevention and Patient Safety** – increase our quality performance
- **Personal Accountability** – all physicians and departments assume accountability for quality and excellence of service

Population Management for Chronic Conditions

The I's have it

- Integration – Med Group, Hospital, and Insurance all in one system – develop the right systems and most efficient workflow
- Unified cost structure that creates Incentives allowing you to do the right thing – capitated payment for the system or population
- Clinical Information systems that allow for population management and the right thing to get done easily (EBM, reminders, monitoring, feedback)
- Culture of Quality Improvement – collaboratives, shared innovation, dissemination of best practices – find the right ways to do things
- Expertise in Implementation – know how to diffuse and drive changes in the organization using our infrastructure and culture

Population Management and Personalization of Care Spectrum

Population Management

- All areas – prevention, episodic and acute care, chronic care, and catastrophic care
- Stratification – different levels of care depending on the risks and intensity of interventions
- Very IT and data dependent, systems dependent

Personalization of Care

- Offering many options for engagement in the system but tied to a personal relationship with your PCP and other providers – DOV, web, phone, etc.
- Individualization around your needs – self management, self care, shared decision making

Operational-ize Quality

- **Art to science, quantitative over intuitive**
- **Clinical quality improvements based on sound, evidence-based medicine**
- **Data and information used to understand successful practices and measure performance**
- **Performance improvement tools shared and adapted locally**

“Give me a lever and I can move the world” — Archimedes

Types of Levers Available to Improve Quality

■ **Administrative Levers**

- Help us get credit for the work we are already doing
- Focused on areas including: data accuracy, standards of measurement and timing of care

■ **Access Levers**

- Help us address operational barriers
- Focused on productivity, availability of appts, and direct booking

■ **Population Management Levers**

- Help us target patients for outreach and inreach
- Focused on patient identification, care management and monitoring

■ **Clinical Practice Levers**

- Help us give the right care every time
- Focused on clinical practice adherence

■ **Strategic Allocations**

Evolution of Population Management for Chronic Conditions in NCal

1996

Initial investment in the infrastructure and programs for high risk members particularly those impacting the ED and Hospital – Level 2 and 3 – care/case management



2005

Population Management all levels, patient centered, supporting proactive teams with PCPs managing their panels – Levels 1-3

Populations where we are currently focused for Chronic Conditions Management

- **Cardiovascular Risk Management –**
 - **PHASE – CAD, Diabetes, Stroke, CKD, PVD, Depression as a comorbidity, and Hypertension**
 - **Some work in pre-diabetes and Metabolic syndrome**
- **Asthma – adult and pediatric with a combined approach**
- **Heart Failure – REF (Reduced Ejection Fraction) and PEF (Preserved Ejection Fraction)**
- **Chronic Pain**
- **Case management of High Utilizing and High Risk members**
- **Obesity – all four levels – pediatric, adult weight maintenance and prevention, high risk members needing weight loss, and severe obesity**

Population Management Levels of Care

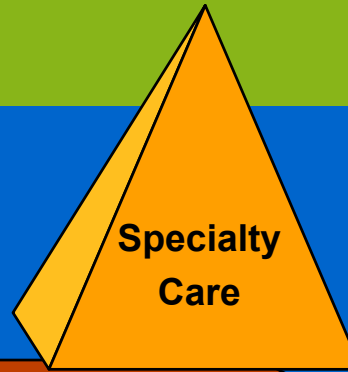
Advanced Disease

Complex Co-morbid Conditions
Complex Psychosocial Issues
Frail Elderly

Need close surveillance of symptoms, medication titration, and intensive self-management education:

- Not in control
- Adherence problems/ Depression
- Complex medication regimen
- Co-morbid conditions

- Need Medications
- Under Control
- Lifestyle Changes



Level 3
1-5%

Specialty MD Care
Coordination with case/care management, eCare



Level 2
20-30%

Nurse or PharmD Care Management
PMA with MD
eCare



Level 1
65-80%

PCP Care, PMA, Coach, Pharmacist
eCare, Web

The Optimal Visit for Diabetes

4 Drug Interventions

- Beta Blockade
- Antithrombotic Medication
- Lipid Lowering Medications
- ACE Inhibition

3 Risk Factors to Control

- Blood Pressure
- Lipids
- Blood Glucose

4 Lifestyle changes

- Tobacco Cessation
- Physical Activity
- Healthy Eating
- Weight Management

Plus

- Renal screening
- Retinal Screening
- Pneumovax, flu vaccination
- Foot Care
- Medicare Coding
- Colon and breast CA screening

AND whatever the patient came in for

Population Management

■ **Departure from reliance on 1:1 Doctor/Patient encounters**

- Is a shift from trying to accomplish everything in the office visit
- Involves treating the ENTIRE population, not just those individuals accessing care
- Supports providers with systems and resources to make the right thing easier
- Applies to both outpatient and inpatient quality improvement areas

Tools for PHASE – Non- DOV (Doctor Office Visit) care

A Practice Management tool – helps the MA to improve panel management for a provider for patients at risk – does not require individual DOVs– more efficient and effective in current implementation – tool available 7/2005

Pharmacy Agreement to Initiate Meds and eventually track and manage the more difficult patients – pilots hopefully in 2005 with further implementation 2006?

eCare tool for individualized care on the web to manage behavior change and medication titration to be developed for Hypertension and Diabetes initially – develop and pilot in 2005 and 2006 with roll out in 2007?

Population Management Work Flow

Start

Program Assistant :
Prints 10 structured worksheets containing CV risk factor information including:

- Labs
- Medications
- Blood pressure
- Immunizations
- Allergies
- PCP visit info
- Care Management or classes



MD:
reviews worksheets, identifies appropriate interventions, and checks off instructions for Program Assistant to communicate to the patient, including:

- Lab studies
- Medication adjustment
- Referrals
- F/U appointments

Requires approx. 15 min per 10 worksheets



Program Assistant:

- Contacts patient in doctor's name and communicates interventions and/or referrals, collects other information (i.e. Aspirin use) as indicated by the physician on the worksheet
- Faxes or calls Rx to Pharmacy
- Sends Lab requisition Books classes/ TAVs/appointments
- Enters data
- Confirms patient allergies and current medications

Requires 10-20 min/pt



Program Assistant :
enters information regarding follow-up interval into a tracking system. And places worksheet in outpatient chart.



Outcomes

- **Patients like it. They are delighted their doctor is “calling them.” They don’t miss work!**
- **Physicians like it. It enhances professional satisfaction. PCP maintains responsibility. It enhances the physician-patient relationship**
- **Quality improves**
- **It is efficient and helps to manage a panel of patients**

Effective Population Management Approaches

Population At Risk	Structure to Reach 100% at Risk	How to Leverage PCP
Diabetic/PHASE	Panel Management System	Panel Management Assistant
Pre-ESRD	Panel Management System	Panel Management Assistant
Population at Risk for Breast Cancer	100% Prospective Outreach in MD name	MAs, modified workers
Asthma Population	100% Quarterly Outreach to patients not at A:I ratio	CCM RN, calling in PCP's name
Low-Utilizer Population	In pilot: phone and letter outreach to for BP/lipid screen	Health Education and Health Coach for risk reduction

What is eCare?

eCare for Moods is an Internet-based, interactive, patient-centered, chronic care management program for bipolar and depressed patients

eCare:

- **Offers individualized care**
- **Improves access**
- **Provides educational tools that maximize patients' self-management skills**
- **Teaches patients how to get support from their own environment**

Functionality - 1

- **Monitors symptoms, early warning signs, triggers, coping strategies**
- **Monitors medications and side effects**
- **Generates alerts to clinicians**
- **Offers interactive educational courses**

Functionality - 2

- **Summarizes patient's health**
- **Allows secure messaging**
- **Offers asynchronous discussion groups**
- **Generates reports for quality control**
- **Has calendar and task list**

Introducing Personalized Population Care Management (P²CM)

“Traditional models” of Population Care Management have been challenged to consistently improve the quality of care and demonstrate reduced cost.

Kaiser has a unique opportunity to introduce a new approach - Personalized Population Care Management (P²CM).*

KP's unique strengths and proven assets

Personalized Population Care Management (P²CM)

- KP's integrated delivery system
- Team-based approach to care
- Electronic Medical Record
- “Best in class” care management programs
- Evidence-based medicine guidance
- Breadth and depth of clinical experience and data

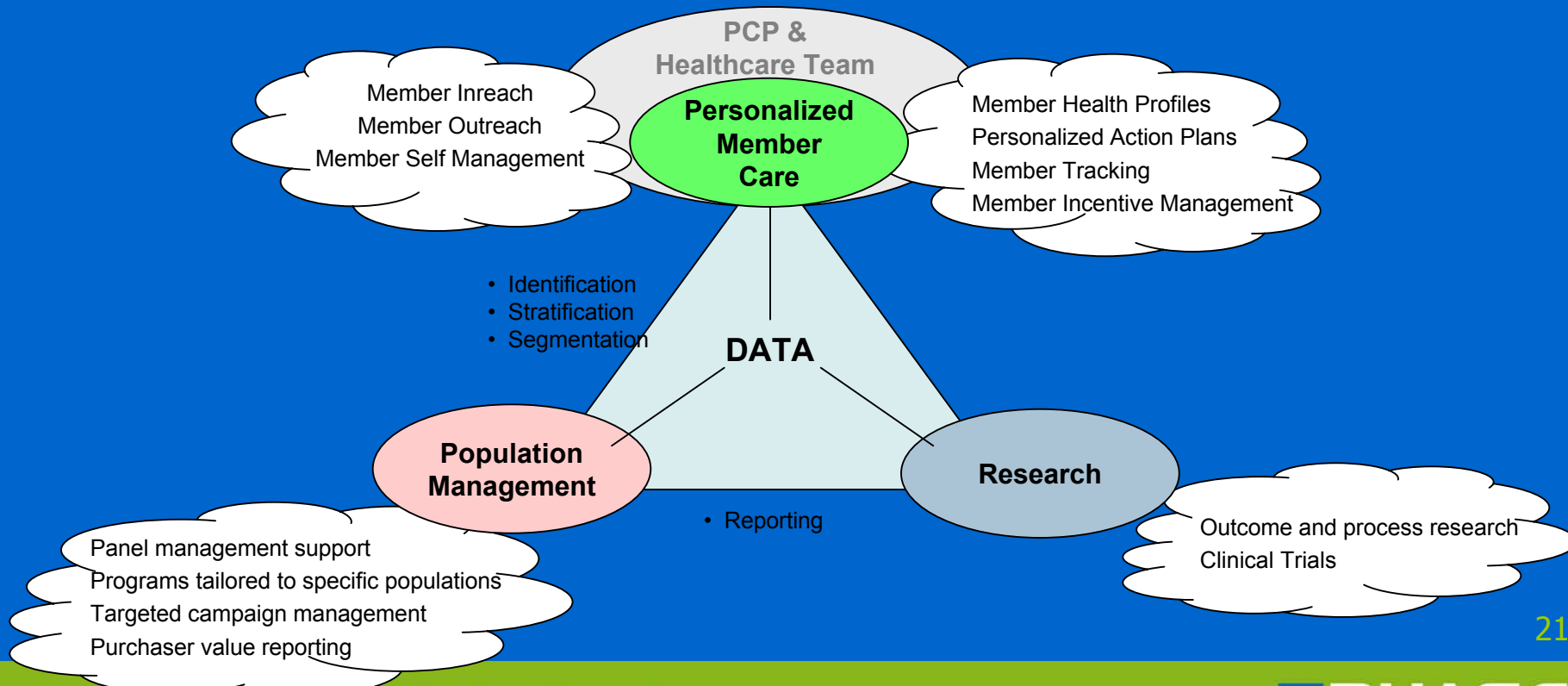
- A “whole member” and “whole population” approach
- Personalized member action plans
- Care location/access based on member preferences
- Proactive identification of risk and care gaps
- Active promotion of healthy behaviors and self responsibility
- Tailored programs and support to fit employer specific populations
- Clinical outcome and performance reporting
- Purchaser value reports

* PCIS will provide the information support service for P²CM

PCIS Overview

The PCIS initiative will focus on three key components of delivering world class health care:

- **Personalized Member Care** – tailor care to meet the needs and preferences of each member
- **Population Management** – tailor and manage programs and services targeted at specific populations (i.e., populations are broadly defined as region, employer, physician (PCP) panels, care manager panels, condition specific populations, health risk factors, etc.)
- **Research** – systematically study the effectiveness and efficiency of P²CM programs and services



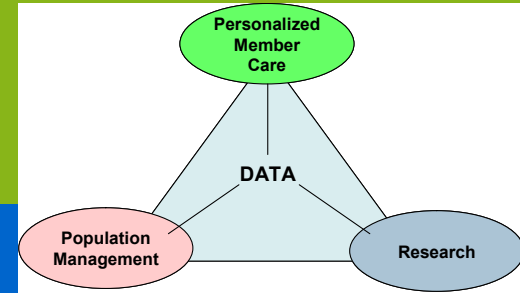
Population Management in KP HealthConnect

4 Buckets of Work – happening nationally in PCIS and in NCal

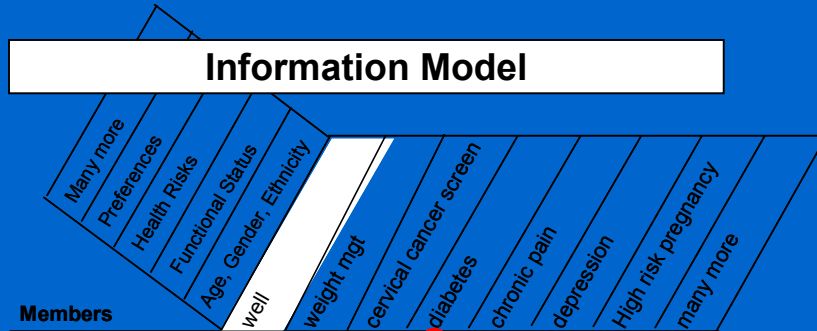
- 1. Enterprise Data Warehouse (EDW) – Population identification, stratification, reporting and monitoring using data – automate to make it more efficient, reliable, and timely – external reporting HEDIS, internal reporting quality improvement, efficiency improvement**
- 2. Tools for doing outreach, inreach, and tracking patients for our care processes – PMT replacing PILOT, PACTS, PHP, capabilities in Epic**
- 3. Supporting care processes with list management – panel management, traditional care management, case management, pharmacy initiation, anti-coagulation**
- 4. Self-care, self-management, and shared decision making support – individualized records, KP online, My Chart, eCare, interfaces with care processes**

P²CM Model

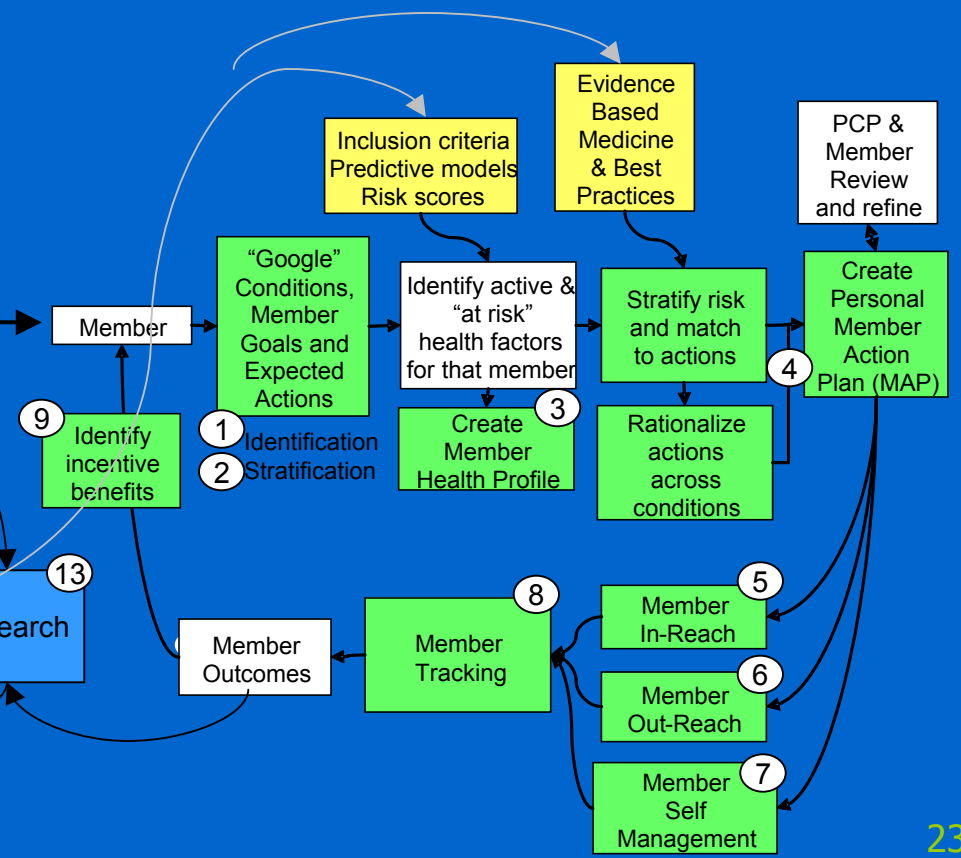
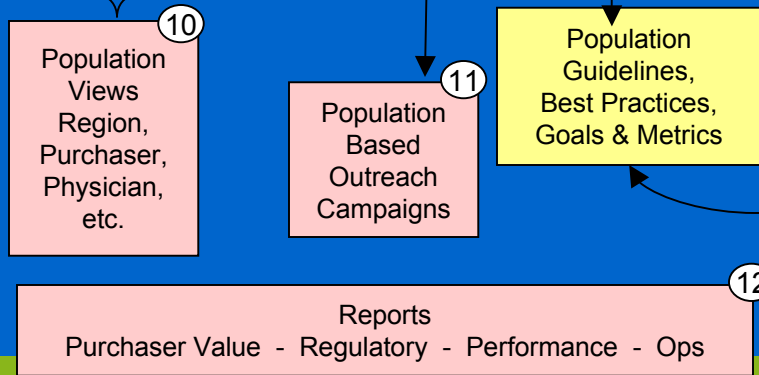
The P²CM model includes multiple capabilities that are supported by the fundamental information model.



Information Model



Members	well	weight mgt	cervical cancer screen	diabetes	chronic pain	depression	High risk pregnancy	many more
Becker, Boris, B	P				P			
Bowie, Jim, A				P		AR	P	
Cabernav, Felicia				P		AR	P	
Camp, Diane, P				P		AR	P	
Dune, Elizabeth				AR				
Grant, Betty L.					P	P		
Hanover, Ralph				AR				P
Member x	P							
Member y				P			P	
Member z								



Health Affairs Issue Nov.-Dec. 2004

- **Fireman article summarizes our work in Disease management of 4 major populations in NCal 1996-2002:**
 - 1. Overwhelming Quality improvement**
 - 2. Relative cost trend savings - \$200 million per year**
 - 3. No absolute cost savings – disease management populations continue to have rising costs**
- **Crossen and Madvig Editorial:**
 - 1. No standard method for looking at ROI in disease management**
 - 2. Mature efficient systems like KP may not see the same kind of cost savings as inefficient systems**

Health Affairs Articles

- Crossen and Madvig continued:

3. Cannot account for increases in productivity, presenteeism, decrease in mortality and economic effect.

Cannot account for cost savings in creating capacity in system.

4. Promise of new IT systems and “chronic care” using non-DOV systems that are patient-centered and promote self-care, self-management, and shared decision making

- Grumbach, Rittenhouse article:

1. Higher degree of conviction and satisfaction among TPMG providers that their group is appropriately focused on quality of care and the organization serves the purpose of improving quality.

Health Affairs Articles

- **Wallack – Strategies to Control Prescription Drug Spending:**
 - 1. KP uses a MD feedback and education approach unique to any other health plan with MD participation in the formulary and decision process**
 - 2. KP with highest generic drug use and lowest drug costs per capita of any health plan, lowest outpatient drug costs - 50% below a HEDIS average nationally, and 40% below Medicare average costs**

THRIVE With PHASE in 2005!

IF YOU CAN'T TAKE IT WITH YOU
STAY LONGER.



KAISER PERMANENTE  **thrive**

Warren Taylor, MD

Contact information:

Email: warren.w.taylor@kp.org

Phone: 510-625-4479 office

Cell: 707-225-7202

**Office address: 1800 Harrison St., 4th Floor QOS,
Oakland, CA 94612**

Administrative Assistant: Janet Marie Walker

Email: janet.marie.walker@kp.org

Phone: 510-625-3946