Population Care: New Frontiers for Nursing Practice

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Agenda

• Introduction to population health
• Shift in model: from old way to new way
• Kaiser Permanente’s story
• New design/approach: implications for nursing
• Systems and panel management: implications for nursing
• Discussion
Why is population health/care important?

- Reduce inpatient and ED utilization
- Increase primary care utilization
- Improve patient/person health through care management
- Match groups of patients to resources
- Identify patients appropriate for tiered level of high intensity interventions
**The Old Way**

- Disease focused – individual care management programs for each disease
- 100% care delivered in hospitals/clinics
- Intensive care management programs expensive
- Paper dependent tracking systems
- Decreased transparency with performance
- Patient/family passive role
- Heavy burden on PC
- Working in silos

**The New Way**

- Shift to population health
- Increased percentage of care delivered virtually
- Care management programs customized
- Electronic tracking
- Full transparency
- Full patient/family engagement
- Community engagement
- Predictive capability using big data
- Team based care-balancing load
- Systems approach, care across the continuum
New Way: moving beyond the team providing direct care
Moving beyond traditional care settings: Activation of our community resources. Expanding the boundaries of the system.
The New System Design
Areas of strongest focus for the future: moving beyond Chronic Care Model to entire population
Systems and technology – Make the right thing easy to do

People Using Technology to Transform Care

We will collect information on individual members’ needs and preferences so that we can customize services to meet those needs.

We will maximize the care delivery options and tools to enhance care and support our providers and staff.

The Care Team

- Family
- Member
- Clinical Team

We will collaborate and agree together on the plan that will best help each member thrive.

Information will be updated real-time and available to the entire care team, and each member will define his/her own care team.

This is me...

- CLINIC TEAM
- HOME
- PLAY
- WORK

We will support the member as the primary health provider.
Steps to achieving population health management

- Understanding the population
- Risk stratification
- Identify broad goals for populations
- Create high level design: matching demand and capacity (tiering)
- Activate the entire team
- Utilize electronic support if possible
- Engage the individual
- Engage the community
- Measure outcomes
- Provide feedback at patient, provider and community level
Old Way:
*Expertise in inpatient and chronic condition management*

New Way:
*Expertise in inpatient and chronic conditions*
*+ Expertise in systems thinking, knowing the population, care across the continuum, patient and community activation*
Necessary skill sets:

- Generic skills for nurses in population care
- Ability to work in telephonic and virtual environments
- High degree of confidence with data/data management
- High degree of confidence with computers
- Coaching skills for self-activation
- Communication skills telephonically and virtually
- Ability to lead integrated inter-professional teams (in-person and virtually)
- Ability to address holistic care that addresses non-medical/non-clinical needs
- **Advance skills requiring additional education**
  - System designs for outreach and in-reach
  - Able to partner with IT architects
  - Able to partner with analytic community
- **Advance practice skills**
- Public health
- Community activation
## New Design – High tech + high touch

### People
- Person-Focused Health
- Chronic Illness Care
- Obesity Prevention
- Palliative Care
- Maternity Care
- Elder Care

### Systems
- Team-Based Care
- Proactive Office Encounter
- Panel Management
- Medication Adherence
- Health Education

### Technology
- Electronic Health Record
- Clinical Decision Support
- Secure Messaging
- Registries
- Outreach by IVR, Text, etc.
- Patient Portal
The System

- Medical Complete Care
- Prevention and Lifestyle Change
- Health Education & Wellness
- Proactive Care
- Regional Outreach
- Medication Management
- Safety Net
- Clinical Information Systems & Decision Support
- Practice Guidelines

Asthma, Breast Cancer, Cervical CIN, CAD, CKD, Colon Cancer, COPD, CVD, Depression, Diabetes, Geriatric, Hepatitis, HF, HIV, Hypertension, Obesity, Osteoporosis, Pneumonia, Sepsis, Rare Diseases, VTE
Online patient engagement tools

Patient instructions

Please check your blood sugar twice a day, before breakfast and dinner, for three days. Send the results by e-mail message to me next week. See the Diabetes featured health topic on kp.org for more information on diet and diabetes.
The system
# Proactive Office Encounter

<table>
<thead>
<tr>
<th>Pre Encounter</th>
<th>Office Encounter</th>
<th>Post Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proactive Identification</strong></td>
<td><strong>Office Encounter Management</strong></td>
<td><strong>Immediate</strong></td>
</tr>
<tr>
<td>• Identify missing labs, screening procedures, access management, kp.org status, etc.</td>
<td>• Vital sign collection / documentation</td>
<td>• After visit summary, after care instructions, follow-up appointments, Health Ed materials, how to access info on kp.org</td>
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<td>• Provide patient instructions prior to visit</td>
<td>• Identify and flag alerts for provider</td>
<td><strong>Future</strong></td>
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<tr>
<td>• Contact patient and document encounter</td>
<td>• Room and prepare patient for necessary exams</td>
<td>• Follow-up contact and appointments per provider</td>
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<td></td>
<td>• Pre-encounter follow-up</td>
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Systems: Panel Management

Tools and processes for population care, to find and close care gaps, applied at the level of a primary care panel.

- Systematic approach
- Prominent role for primary care physician
- Proactive outreach, beyond office visits
- Strong multi-disciplinary/Interprofessional teamwork
- Leveraging technology
Integrated registry systems connect the panel view to the individual patient
## Case Study: Care for patients over 65 (Medicare)

**High potential / high value tactics** – We can improve care across our entire landscape of settings and strategies – to provide the right care at the right time in the right place.

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**Extend the Delivery System**

<table>
<thead>
<tr>
<th>KP Care Settings</th>
<th>Technology Enabled Care Settings</th>
<th>Community Care Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute, Urgent &amp; Emergent Care Encounters</strong></td>
<td><strong>Clinic</strong></td>
<td><strong>Everywhere</strong></td>
</tr>
<tr>
<td>Hospital &amp; ED</td>
<td>Geriatric Emergency Department</td>
<td>Geriatric Specialty Deployment</td>
</tr>
<tr>
<td>Care Transitions</td>
<td>Palliative Care</td>
<td>“Respecting Choices”</td>
</tr>
<tr>
<td>Geriatric ED</td>
<td>Hospital at Home</td>
<td>Primary Care Home Visits</td>
</tr>
<tr>
<td><strong>Ambulatory Care Encounters</strong></td>
<td><strong>Care Management</strong></td>
<td><strong>Remote Monitoring</strong></td>
</tr>
<tr>
<td>Clinic</td>
<td>Geriatric Medical Home</td>
<td>Access to Community Social Services</td>
</tr>
<tr>
<td>Geriatric Specialty Deployment</td>
<td>&quot;Respecting Choices&quot;</td>
<td>Community</td>
</tr>
<tr>
<td><strong>Population Care Encounters</strong></td>
<td><strong>Call Centers / KP.Org</strong></td>
<td><strong>Social Networking</strong></td>
</tr>
<tr>
<td>Care / Case Management</td>
<td>Self Care KP.org</td>
<td>Internet Care Communities</td>
</tr>
<tr>
<td>Automated Care Mgt</td>
<td>Integrated Member Assistance</td>
<td>Self Care System Mobile Apps</td>
</tr>
<tr>
<td>Clinical Onboarding</td>
<td>Call Centers / KP.Org</td>
<td>Integrated Complex Care</td>
</tr>
<tr>
<td><strong>Social Networking</strong></td>
<td><strong>Assisted Living Rounding</strong></td>
<td><strong>SNF Rounding</strong></td>
</tr>
<tr>
<td><strong>Remote Monitoring</strong></td>
<td><strong>Community Paramedicine</strong></td>
<td><strong>Continuum of Care</strong></td>
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**Empower Members and Caregivers**

- "Respecting Choices"
- Integrated Complex Care
- Access to Community Social Services
A Case Study: Community Navigators
Gaps in current knowledge base

• Confidence working across boundaries
• High skill with teaming beyond nursing
• Coaching rather than directing
• Experience in integrated delivery systems
• Experience in communities
• Provision of telephonic and virtual care
• Participation on team of virtual providers
• Ownership of “unseen patients/population”
• Looking at people over life time “the long view”
• Confidence in providing patient directed care