Alide Chase Consultant, LLC

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

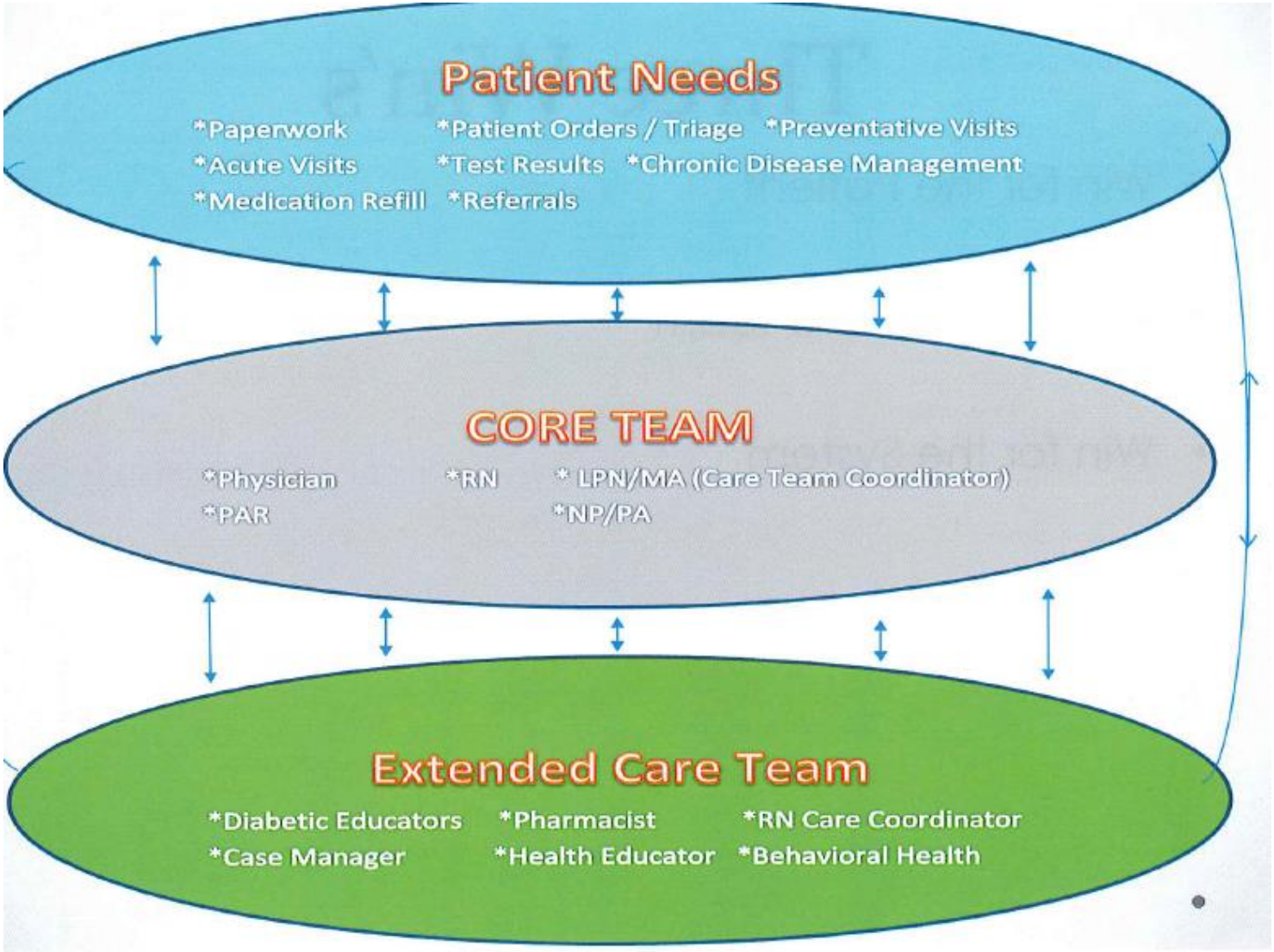
The Old Way

- 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

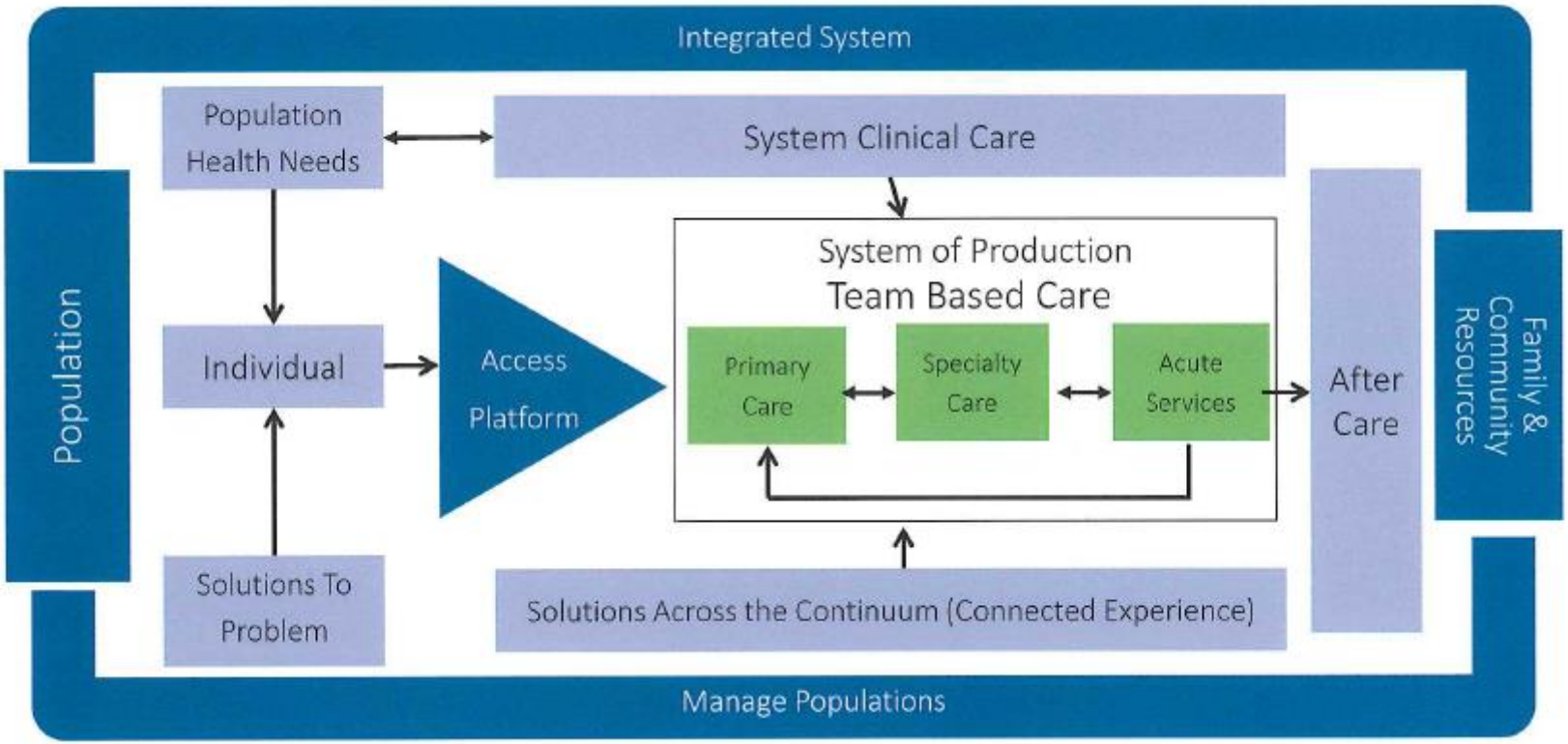
New Way: moving beyond the team providing direct care



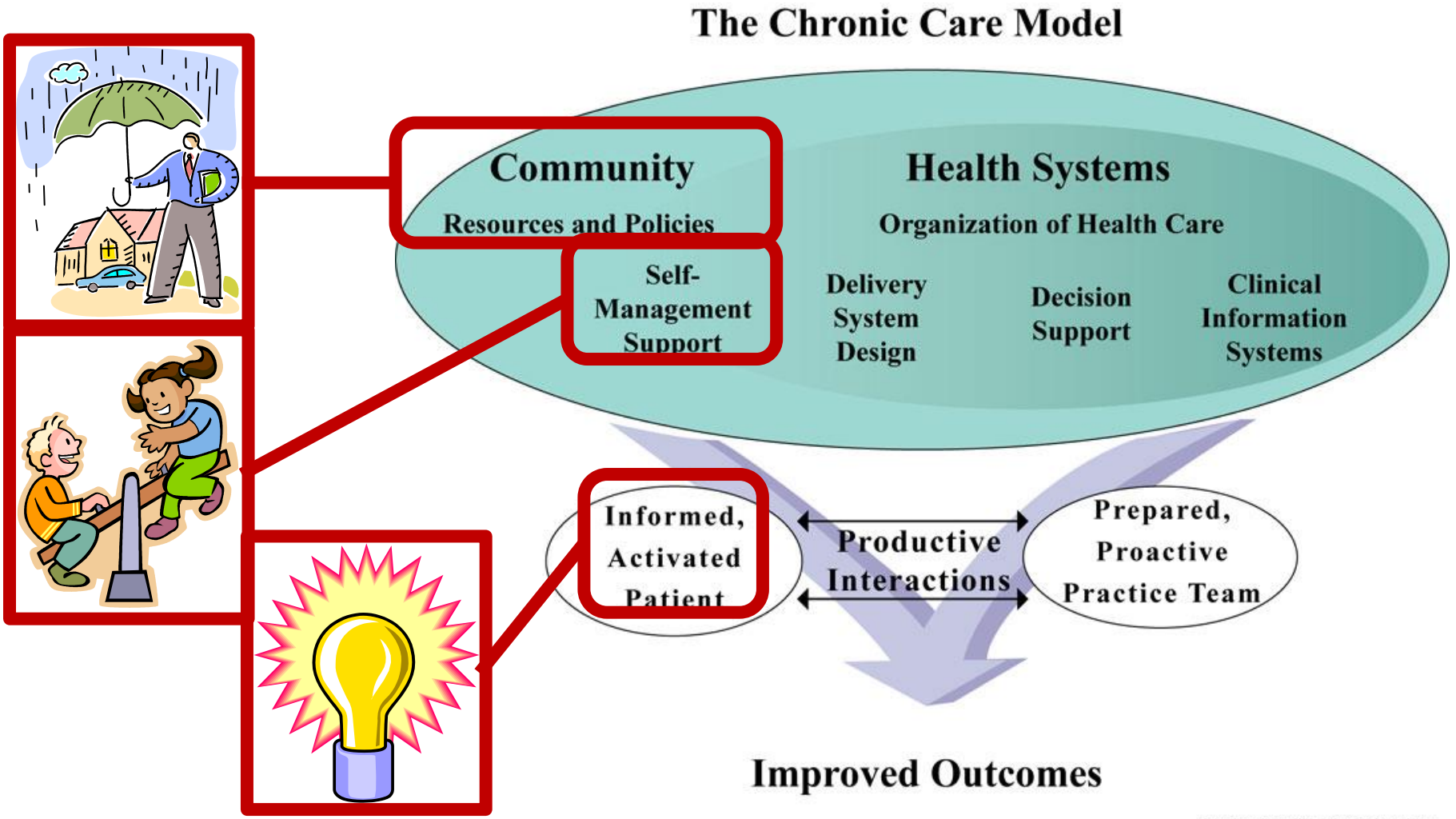
Moving beyond traditional care settings:
Activation of our community resources. Expanding the boundaries of the system.

bellinhealth

The New System Design

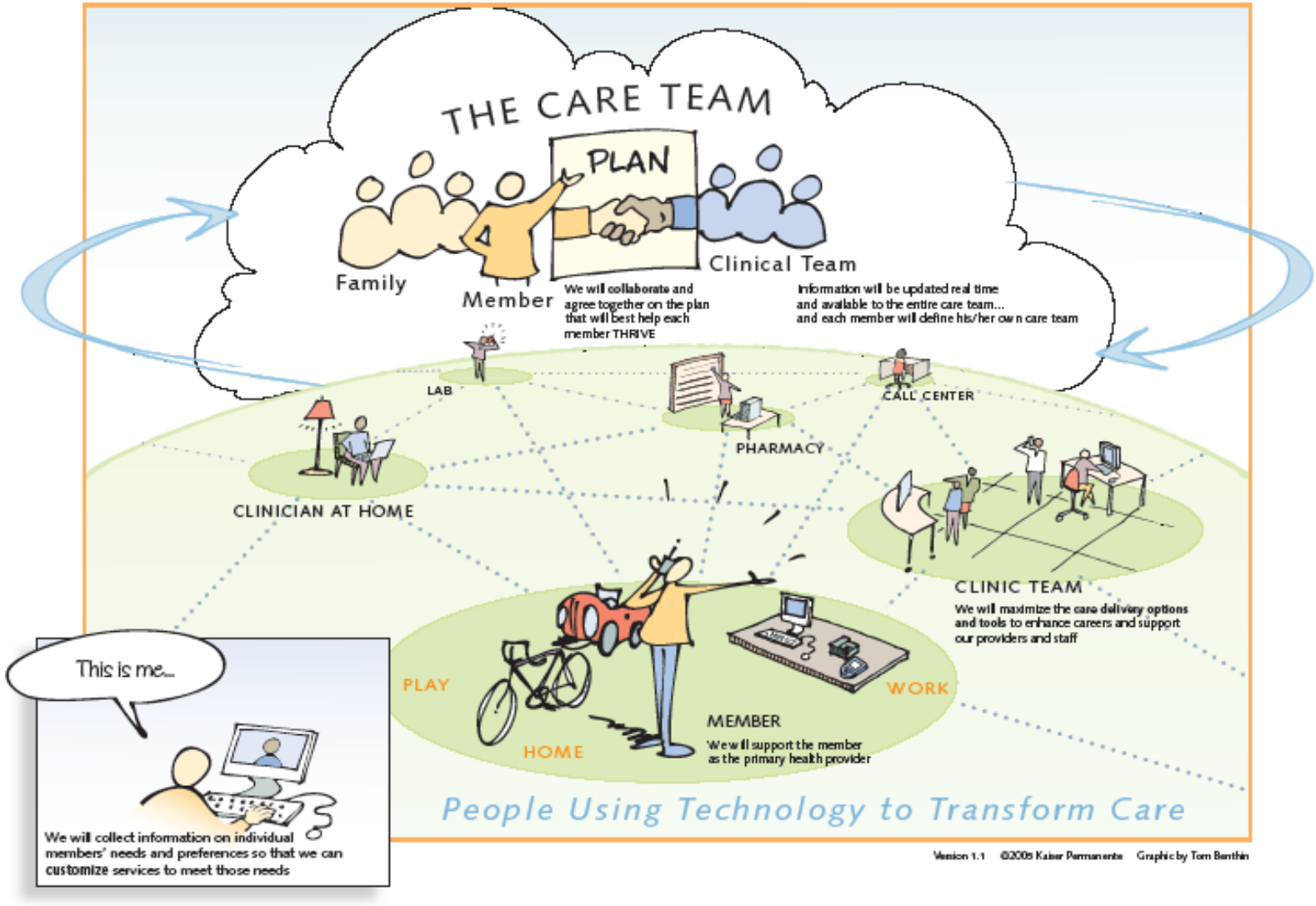


Areas of strongest focus for the future: moving beyond Chronic Care Model to entire population



Developed by The MacColl Institute
® ACP-ASIM Journals and Books

Systems and technology – Make the right thing easy to do



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

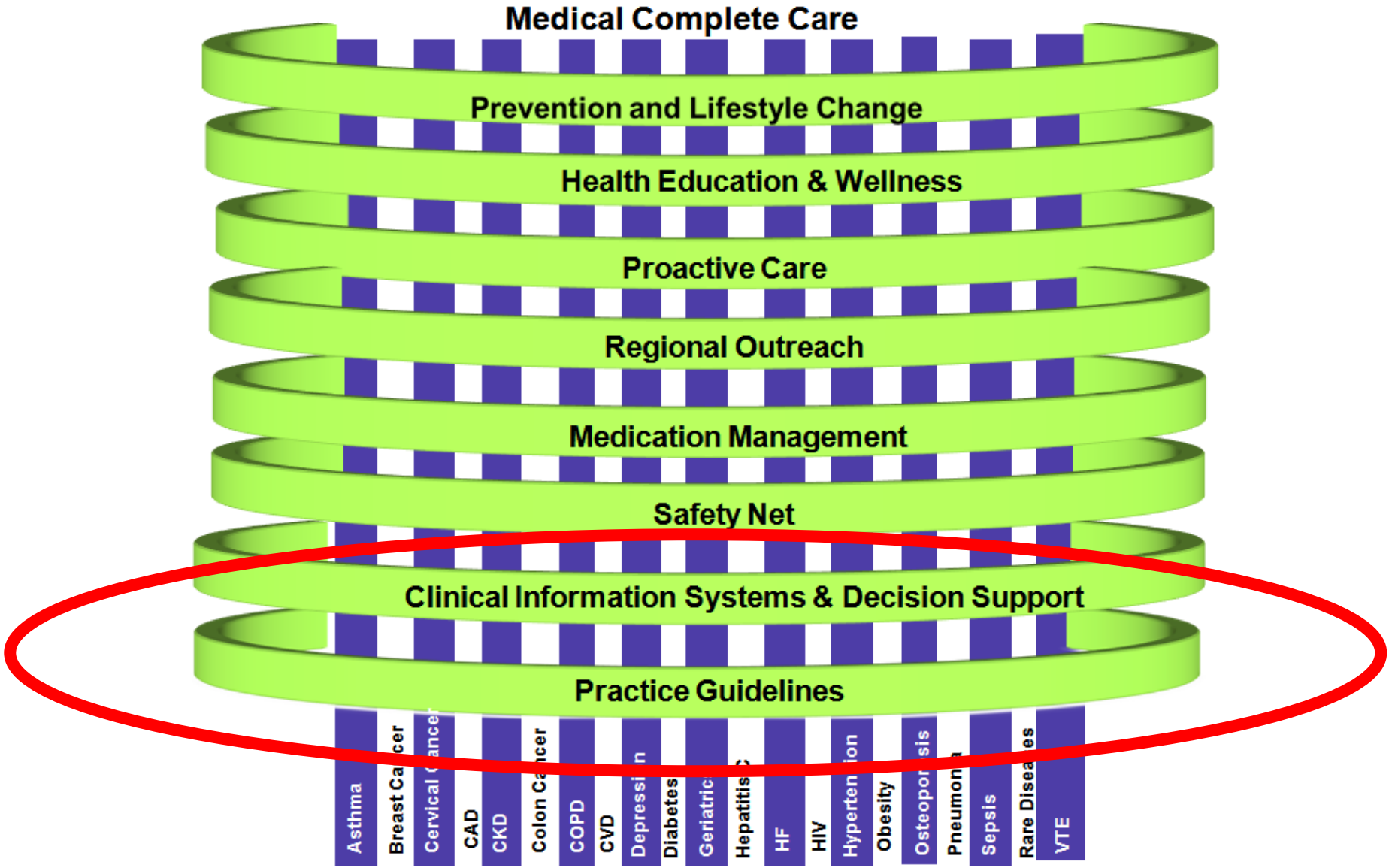
Systems

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

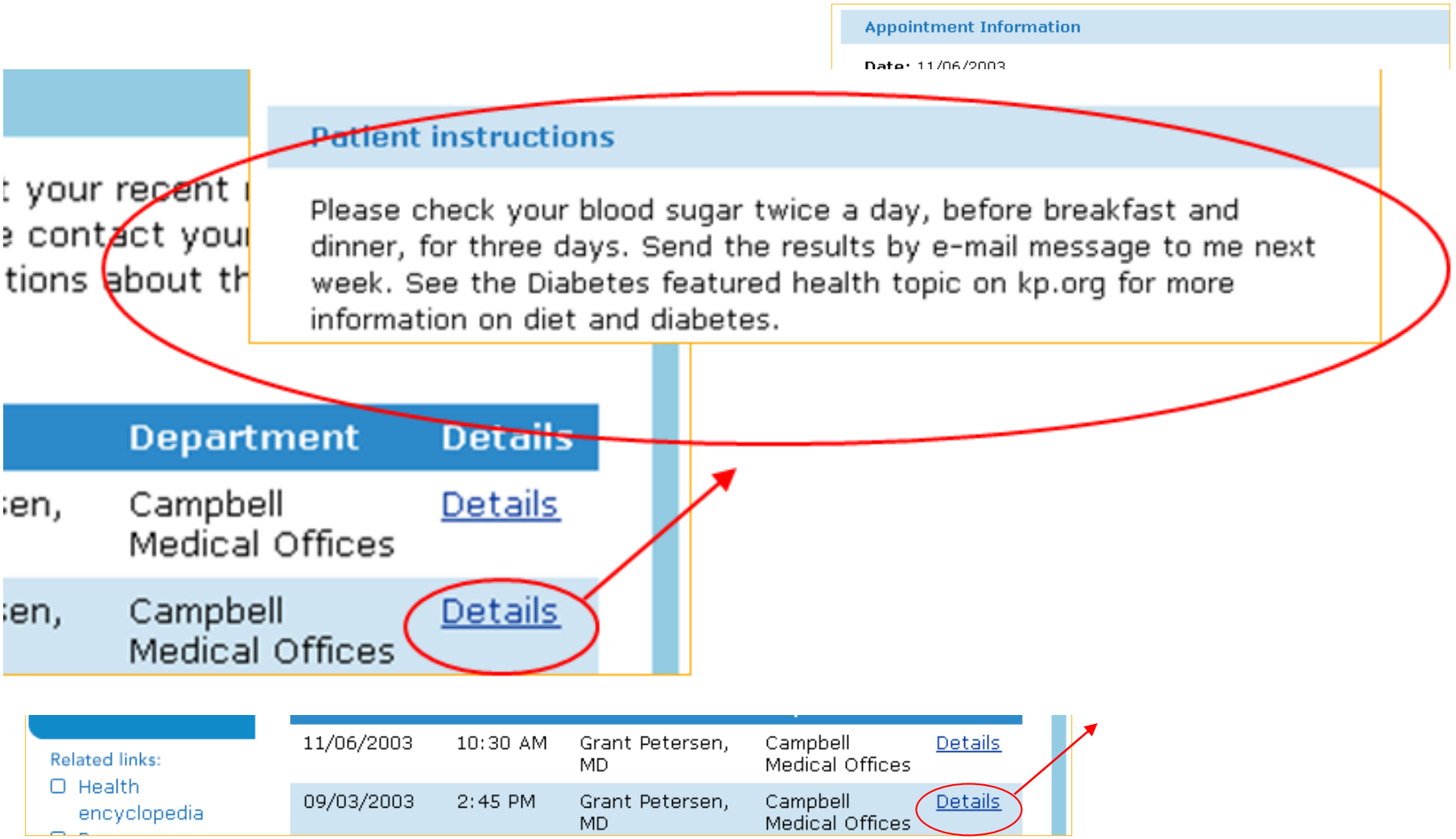
Technology

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

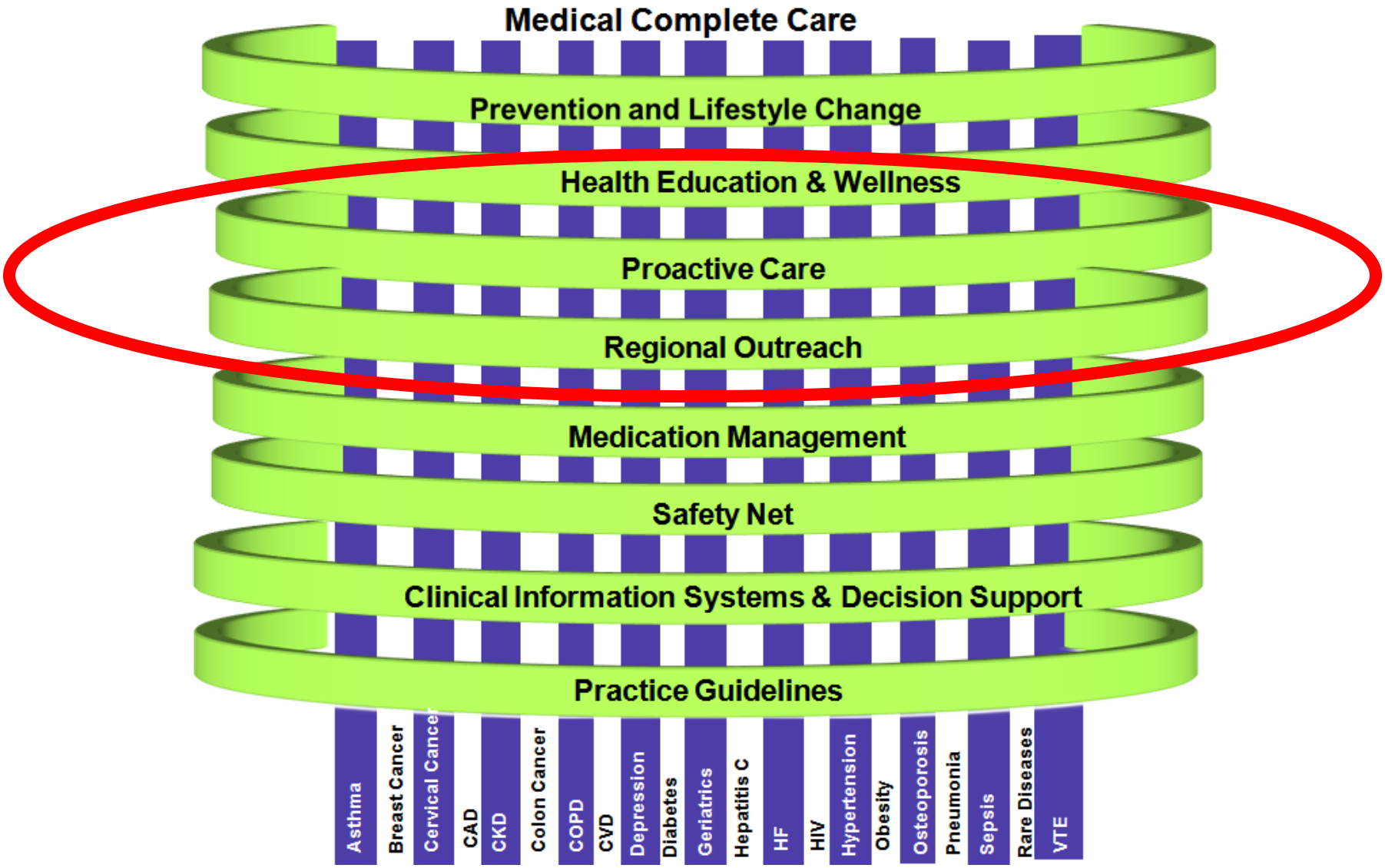
The System


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 Cancer
CAD
CKD
Colon Cancer
COPD
CVD
Depression
Diabetes
Geriatric
Hepatitis C
HF
HIV
Hypertension
Obesity
Osteoporosis
Pneumonia
Sepsis
Rare Diseases
VTE

Online patient engagement tools



The system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Proactive Office Encounter

Pre Encounter

Proactive Identification

- Identify missing labs, screening procedures, access management, kp.org status, etc.
- Provide patient instructions prior to visit
- Contact patient and document encounter

Office Encounter

Office Encounter Management

- Vital sign collection / documentation
- Identify and flag alerts for provider
- Room and prepare patient for necessary exams
- Pre-encounter follow-up

Proactive Office Support

- Phone calls
- Letters
- E-mail
- Inbox Management

Post Encounter

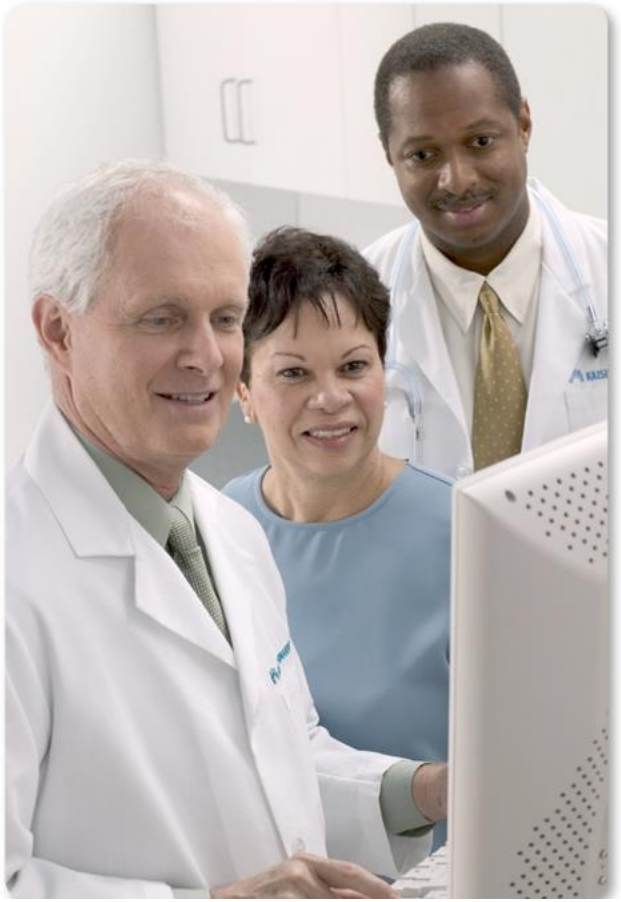
Immediate

- After visit summary, after care instructions, follow-up appointments, Health Ed materials, how to access info on kp.org

Future

- Follow-up contact and appointments per provider

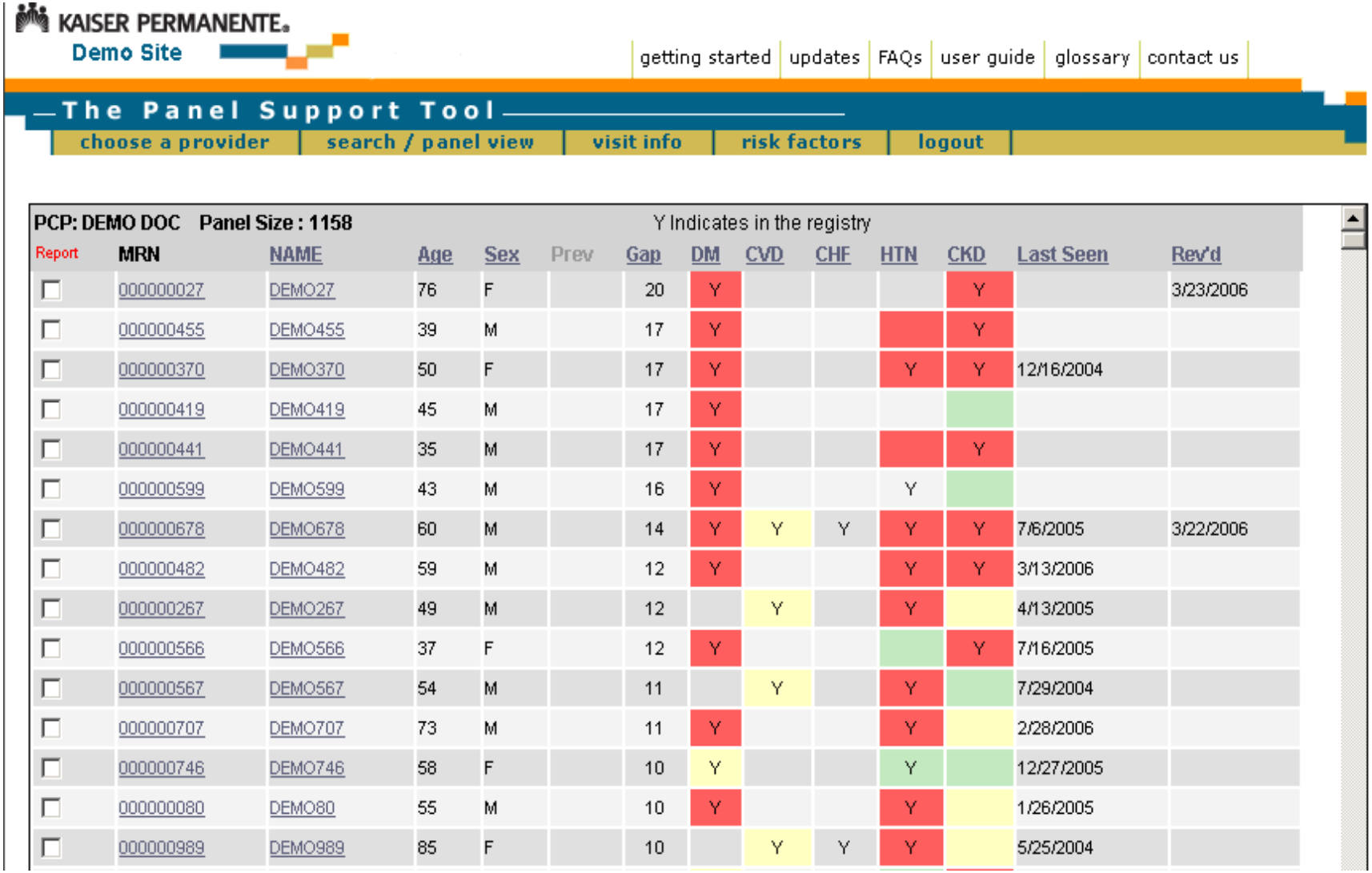
Systems: Panel Management



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



Report	MRN	NAME	Age	Sex	Prev	Gap	DM	CVD	CHF	HTN	CKD	Last Seen	Rev'd
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☐	000000370	DEMO370	50	F		17	Y			Y	Y	12/16/2004	
☐	000000419	DEMO419	45	M		17	Y						
☐	000000441	DEMO441	35	M		17	Y				Y		
☐	000000599	DEMO599	43	M		16	Y			Y			
☐	000000678	DEMO678	60	M		14	Y	Y	Y	Y	Y	7/6/2005	3/22/2006
☐	000000482	DEMO482	59	M		12	Y			Y	Y	3/13/2006	
☐	000000267	DEMO267	49	M		12		Y		Y		4/13/2005	
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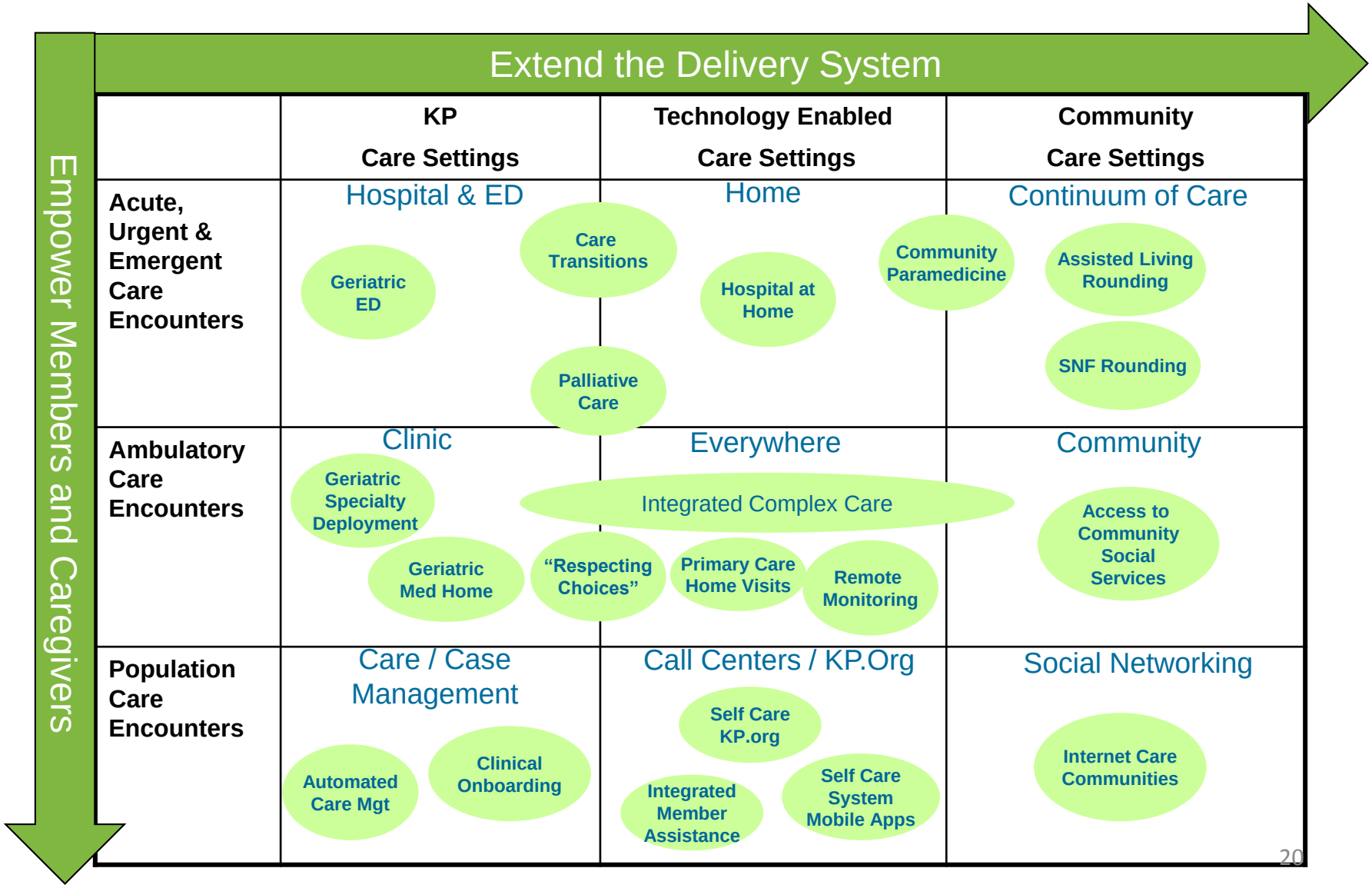
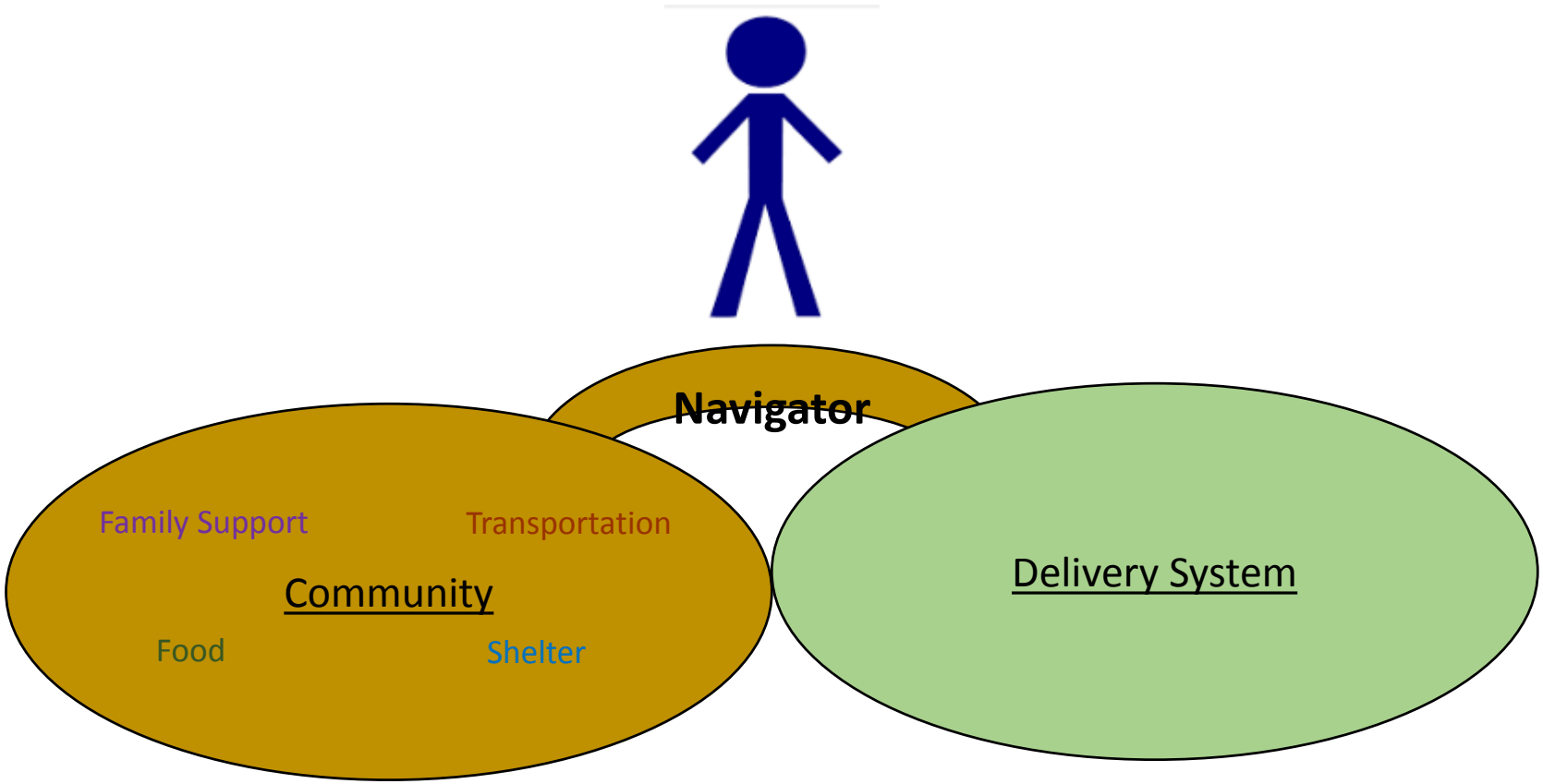
☐	000000746	DEMO746	58	F		10	Y			Y		12/27/2005	
☐	000000080	DEMO80	55	M		10	Y			Y		1/26/2005	
☐	000000989	DEMO989	85	F		10		Y	Y	Y		5/25/2004	

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.



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