Quality and Innovation Centers: Kaiser Permanente

By: Alide Chase, senior vice president Medicare Clinical Operations and Population Care
And
Lisa Schilling, RN MPH vice president Healthcare Performance Improvement
Care Management Institute

December 10, 2012
8:30am – 12:00 pm

Our Numbers

- 8 regions serving 9 states and the District of Columbia
- 8.9 million members (as of 2/11)
- 15,000 physicians
- 164,000 employees (including 45,000 nurses)
- 37 medical centers (with hospitals)
- 454 medical offices (ambulatory care buildings)
- $44 billion operating revenue (2010)
Kaiser Permanente Quality Improvement Journey

2005-2007

- Established strategic partnership with IHI
- Develop enterprise quality strategy
- KP HealthConnect implementation begins
- Assess baseline capability to improve
- Establish KP’s big dots the “Big Q”
- Some best performance in KP and high variation
- Establish IHI scholarship program for KP and safety net

2008-2010

- Develop Improvement Institute
- Hire master black belt mentors
- Adopt IHI’s execution model in medical centers
- Focus on alignment, portfolio management achieving scale
- Deepen commitment to analytics, evaluation and research
- KP HealthConnect fully implemented, optimizing
- More PSQI graduates than any other organization
- Targeted participation in IHI programming based on strategic need

2011-Beyond

- Align innovation, improvement in key strategies
- Focus on technology integration, informatics and improvement at scale
- Develop deep capability at regional levels
- Expand capability to operate as a learning organization via networks and KM
- 4 part series published in the Joint Commission Journal
- KP NCQA results, Medicare Stars best in class performance across KP
- Created Clinical Effectiveness Research Center
- Focus on total health

Our system is based on the attributes of high performing organizations

KP builds capability in these six areas in order to achieve breakthrough performance

Leadership  Learning  Best quality
Systems  Capacity  Best service
Measurement  Culture  Most affordable
Best place to work

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High Performing Organizations Build Culture and Capability

<table>
<thead>
<tr>
<th>Principles</th>
<th>What we “do”</th>
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<tbody>
<tr>
<td>• Define organizational needs</td>
<td>• Align with strategy</td>
</tr>
<tr>
<td>• Create system view</td>
<td>• ID drivers and portfolios</td>
</tr>
<tr>
<td>• Plan/ manage improvement</td>
<td>• Build capability to improve</td>
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</table>

Top down
Reduce variation
Learning system

- Economic and social context for change
- Models of workplace learning
- Team performance

- Engaging the hearts and minds of the front line
- Creating “line of sight” to strategic goals
- Define high performing unit-based teams

Bottom up
Learning and improvement

Building Will

Define Breakthrough goals

Provide Leadership for Large system Projects

Manage Local Improvement

Provide Day-to-Day Leaders for Micro Systems

Develop Capability

Spread and sustain

Source: IHI 2008

Source: IHI 2008

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Ideas: Manage Local Improvement

Identifying Levers of Improvement: Driver Diagrams
Harvesting of Ideas: Scanning

Problems

- Elder Health
- Falls With Injury

Just Do It
- Palliative Care Program

Improve It or Adopt It
- Length of Stay for THR

Create It
- New Model of Elder Care
- Toileting & Rounding Bundle
- ID high risk from medications
- Injury-free Floors; Delirium Prevention

Outcomes

- Healthy Quality of Life
- No Falls With Injury

Develop Capability for Execution

Define Breakthrough goals

Spread and sustain

Manage Local Improvement

Provide Day-to-Day Leaders for Micro Systems

Develop Capability

Source: IHI 2008
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Content: What Skills Do We Need?

- **Many People**
  - Everyone
  - (Staff, Supervisors, UBT lead triad)
- **Few People**
  - Change Agents
    - (Middle Managers, Stewards, project leads)
  - Operational Leaders (Executives)
  - Experts

A key operating assumption of building capacity is that different groups of people will have different levels of need for PI knowledge and skill.

Our approach will be to make sure that each group receives the knowledge and skill sets they need when they need them and in the appropriate amounts.

Developing deeper capability to achieve big results over time

- **September 2008**
- **June 2009**
- **2010 & 2011**

**Wave 2**
- 5 regions
- 65 Improvement Advisors
- 300 Operations managers
- 3,500 Front line staff
- IHI Forum

**Wave 3**
- 7 regions
- 300 Improvement Advisors
- 35 UBTC's
- 1,250 Operations managers
- 8,000 Front line staff
- IHI Forum and courses

**Wave 4 & beyond**
- All Regions
- 500 IA's
- 15 internal faculty Mentors
- 3,000+ Operations Managers
- 20,000+ Front line staff
- IHI Forum and courses

Learning and sharing systems regionally and program-wide Improvement Institute

- **Complete**
- On-boarding
- Implementation
- Expansion
- Continuous Improvement

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### Regional Case Study: Sepsis Care Across 20 Medical Centers

**Video NCAL Sepsis**
Multi-hospital Results: Reducing Mortality from Severe Sepsis

- 26% Decline in mortality
- 18% Decline in LOS
- 1,135 Lives saved
- $56MM Over-utilization avoided

Tremendous Improvement in Member Satisfaction with the Health Care they Receive

Ambulatory Service Performance: CAHPS Health Care Rating

Drivers
- Focus on leadership
- Alignment of goals
- Engagement of front-line

Key Initiatives
- Access improvement practices
- Communications
- Culture of Excellence

Legend:
Blue = Program trend
Black = CAHPS benchmark

Interregional CAHPS improvement workgroup formed – sharing best internal and external practices

75th percentile

% of members rating overall health care in last year as 8 or 9 on a scale of 0 to 10 (from worst possible to best possible)
Leveraging the Power of Electronic Health Records: Improved Ambulatory Care
Ambulatory Performance: HEDIS Composite

<table>
<thead>
<tr>
<th>PY Year</th>
<th>Drivers</th>
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<tbody>
<tr>
<td></td>
<td>Population care</td>
</tr>
<tr>
<td></td>
<td>Decision support</td>
</tr>
<tr>
<td></td>
<td>KP.org</td>
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</tbody>
</table>

Clinical Effectiveness
Inpatient Outcomes: Hospital Standardized Mortality Ratios

DO NOT INCLUDE IN AUDIENCE PACKET – FOR LIVE PRESENTATION ONLY
Current Challenges
Alide Chase, SVP, Medicare Clinical Operations and Population Care

Medicare Care Delivery

Our Big Challenges
How to provide outstanding care in both clinical quality and care experience to our Medicare members while reducing total cost of care?

Answer:
• Reliably execute on proven care
• Remove variation
• Transform care delivery
• Design entire system to be member/patient focused
Values

- KP’s commitment to high quality of care and an excellent service experience are top priorities in the organization.
- This commitment remains in place and serves as a “true north” as we face significant challenges with health care reform.
- The focus on patient safety, particularly in our hospitals is a key component of the plan.
- All of the Medicare initiatives will result in improved quality and service with improved efficiency and effectiveness that will help make healthcare more affordable for our members.

Our National Work

- Spread and Execution of Proven Care
  - Reduce Variation
  - Accelerate the Development Cycle
- Align Care to Member Needs
- Engage all of Kaiser Permanente
Care Delivery Needs Differ Across Segments

Medicare Segmentation

- Healthy
- Chronic Conditions
- Advanced Illness
- Severe Frailty/End of Life

Care Needs

- Usual Care
- Population Care
- Complex Care

Percent of Members

- Healthy: 15 to 20%
- Chronic Conditions: 60 to 65%
- Advanced Illness: 10 to 15%
- Severe Frailty/End of Life: 5 to 7%

PMPM Expense Ratio

- Healthy: 1X
- Chronic Conditions: 2-3X
- Advanced Illness: 5-8X
- Severe Frailty/End of Life: 15-20X

Data Capture and Predictive Ability

Personalizing Care through Segmentation

- SEGMENT 1: Healthy / Robust
- SEGMENT 2: Chronic Conditions
- SEGMENT 3: Advanced Illness
- SEGMENT 4: Severe Frailty / End-of-Life

Moira M Belkinoff | 510-267-2976
Insert Kat diagram here

Medicare Plan: Three Buckets of Work

First 5
What we know and do well

- Palliative Care
- Transitions
- Bone Health
- SNF ALF Rounding
- Clinical Onboarding

Unwarranted Variation

- Decrease unwarranted admissions & readmissions
- Decrease unwarranted variation in services

Transformation

Unwarranted Variation

- New provider roles
- Medical home
- Self Care
- Automation
- Care Planning
- Telemedicine
- Technology-enabled community health workers

Excellence

28
Unwarranted Variation

Act and Go Beyond

Selected areas based on KP’s actionability and improvement of care:

- EKG, angiography and imaging tests for low risk cardiac patients
- Antibiotics and imaging for sinusitis and headache
- Percent of women with second pap smear within 2 years, 6 months
- Redundant visits year after breast cancer is cured
- Screening PSA in men over 75 years of age
- Overly tight glucose control in some older adults with diabetes
- Using anticholinergic medications as a first line treatment of urinary incontinence in older adults
Transformation

Scanning Results

- We have identified promising tactics across all care delivery domains
- No single strategy (internal or external) was both “high potential impact” and “just spread now”
- Need to design and test our hypotheses for new operations and workflows to achieve our goals

Innovation that Supports Transformation Now

- Hospital to Home: Identify way to move inpatient close to home
- Clinic to Home: Move ambulatory care from clinic to “Everywhere” with telemedicine
- Integrate Complex Geriatric Care: Segment 3 & 4

Example of Programs Identified
**Transformation Spaces**

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.

<table>
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<tr>
<th>KP Care Settings</th>
<th>Technology Enabled Care Settings</th>
<th>Community Care Settings</th>
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<tbody>
<tr>
<td>Acute, Urgent &amp; Emergent Care Encounters</td>
<td>Hospital &amp; ED</td>
<td>Home</td>
</tr>
<tr>
<td>geriatric ED</td>
<td>Care Transitions</td>
<td>Virtual Ward</td>
</tr>
<tr>
<td>Ambulatory Care Encounters</td>
<td>Clinic</td>
<td>Everywhere</td>
</tr>
<tr>
<td>geriatric specialty clinics</td>
<td>Primary Care Home Visits</td>
<td>Telemedicine Remote Monitoring</td>
</tr>
<tr>
<td>Population Care Encounters</td>
<td>Care / Case Management</td>
<td>Call Centers / KP.Org</td>
</tr>
<tr>
<td>automated care mgmt</td>
<td>Self Service KP.org</td>
<td>self care mobile app</td>
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**Initial Demonstrations**

KPGG Expectations: Each Participating Region and Demonstration Will:

- Designate a Health Plan and Medical Group executive who will be accountable for the Demonstration outcomes
- Define specific affordability hypotheses that can be quantified
- Set targets and define metric indicators for contributions to affordability, quality, and experience for the Demonstration model, the region and KP-wide, by June 1, 2013
- Show your Demonstration is on a trajectory to hit your end-of-year Demonstration targets by June 1, 2013.
- Show your Demonstration is on a trajectory to hit your regional targets by December 31, 2013
- Be prepared to share learning and progress toward objectives on a quarterly basis beginning in December 2012

- Develop ways to move inpatient care closer to home
- Hospital to Home, Virtual Wards
- Using telemedicine to move ambulatory care from the clinic to "everywhere"
- Virtual visits, Telemedicine, Remote monitoring
- Address the clinical needs and operations to support service delivery for complex members across the continuum; clinic to home to community
- Matching care to need: Think through how operations for the complex "micro-panel" will integrate with the "macro-panel" to achieve greater affordability
Engage the Whole Organization

- Jann’s star clusters here