

Title:

Proactive Office Encounter—Optimal Integrated Care for Every Patient Encounter

Background knowledge:

In the United States only 54.9% of adult patients receive preventive care recommended by medical evidence.¹ The Executive leaders of Kaiser Permanente Southern California aspire to lead the nation in prevention and to transform care delivery from “good to great”.

In support of this goal, Kaiser Permanente Southern California has developed a region-wide “in-reach” system, called Proactive Office Encounter (POE). POE, which was first introduced in 2007, engages staff and physicians to proactively address both preventive and chronic care needs at each patient encounter in primary or specialty care.

The POE system relies on standardized workflows and sophisticated information technology to provide timely and accurate member-specific information to the health care team. Clinicians, labor partners, health care professionals, and administrators worked collaboratively to develop, pilot and introduce the process. An electronic tool was designed in partnership with Kaiser Permanente Southern California Pharmacy Analytical Services (PAS) utilizing the Permanente On-line Interactive Network Tools (POINT) and integration into Kaiser Permanente HealthConnect® (Kaiser Permanente’s electronic medical record system).

While individual physicians, departments, and medical centers had previously implemented various programs to address patient care needs more proactively, this is the first time Kaiser Permanente has brought together a standardized, systematic, and region-wide approach to closing preventive and chronic care gaps.

Since its inception, POE has contributed to sharp improvement in the Southern California region’s clinical quality performance, including **double-digit improvements in colorectal cancer screening, advice to quit smoking, and blood pressure control.**

Intended improvement:

Recognizing the need to improve delivery of health prevention services, Kaiser Permanente Southern California created the POE program to identify and target patients with chronic medical conditions and encourage them to be active participants in their own care. The program uses all members of the clinical care team in a coordinated and collaborative effort to engage, encourage and support patient health. The information and tools provided have helped increased preventive screenings and improved treatment adherence.

Program Summary:

Kaiser Permanente Southern California has over three million Kaiser Permanente members which drive over 12 million outpatient encounters each year. With the introduction of POE, each encounter is an opportunity to optimize the preventive and chronic care provided to patients.

POE aligns with Kaiser Permanente’s Complete Care approach to patient care, in that it focuses patients’ total health, not just the presenting problem or the primary health concern. POE maximizes the ability to positively impact all of a member's health care needs, from wellness and prevention to acute, chronic and end-of-life care.

¹ Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keeseey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H. *The Quality of Health Care Delivered to Adults in the United States*. N Engl J Med. 2003 Jun 26;348(26):2635-45.

Plan Staff Involved:

POE activates all members of the health care team to provide a proactive patient care experience, including physicians, RNs, LVNs and back office support staff,.

Regional and Local Leadership oversee POE to ensure an integrated, standardized approach to deployment, implementation, and ongoing management of the process. At each Medical Center, physicians and administrators for Primary Care and Specialty Care, in collaboration with support service departments (i.e. Laboratory, Radiology), orchestrate the team approach and resources to ensure POE is blended into the culture of the organization.

Regional support includes a Proactive Care Administrative and Physician Lead that maintain standardization and communication of tools, education, workflows, and process design.

HIT Dimensions Utilized:

POE utilizes robust electronic medical information technology and data management systems to provide the health care team with timely and accurate member-specific care gap information.

SmartTools and integrated POE Encounter Checklists within Kaiser Permanente's electronic health records (KP HealthConnect[®]) enhance office efficiency in Adult and Pediatric care when incorporated with designed workflows. POE is utilized before, during and after a patient-initiated visit to improve clinic outcomes by:

Pre Encounter: Staff proactively identifies care gaps prior to the office visit and contacts the patient to address these gaps. Gaps may include lab tests, health screenings, and KP.org registration status. Physicians can then focus on the patient's health concerns and test results at the time of the visit.

Encounter: During the office encounter, office staff follows a standardized work flow, which includes reviewing and updating documentation of chief complaint, vital signs, exercise vitals, medications, allergies and preferred pharmacy. Staff then identify gaps in care through decision support tools (POINT and Best Practice Alerts) and pend necessary orders and/or exclusion codes for the clinician on KPHC. Staff flag any needed screenings and/or uncontrolled conditions for the provider to discuss during the visit. In addition, staff prepares the member and room for any procedures (e.g. pap smear, diabetic foot exam, etc.) and assists the provider through the process.

Post Encounter: Immediately following the visit, staff ensures that patients receive information they need to take the next steps. This may include an after visit summary, after care instructions, health education materials as applicable, information on accessing kp.org and any follow up appointments or referrals. In addition, the patient may be contacted after the visit per the clinician's direction.

Message Support: Underlying all phases of the proactive encounter is message support. Message support was part of the initial design of POE, but was not deployed until late 2008. It has been identified as a key function of Proactive Care and evolved into its own function, POS. POS will not be the focus of this submission, but also applies to Southern California Permanente Medical Group's strategy of Proactive Care in that it impacts back office support with in-basket management. You can refer to the tools developed for POS in the materials provided.

Planning the intervention:

The POE program fosters cooperation among providers by rewarding professionals where quality care goals, many affected by these types of screenings and preventative measures, are achieved. Clinical care teams comprised of doctors, nurses, medical assistants and other staff work together to identify opportunities to engage patients and provide support and encouragement for positive action across the continuum of health care services.

The program's proactive engagement begins for patients before they visit the doctor's office. The process starts with the automated creation of care checklists for all patients whose records indicate gaps in care. Clinical care teams review the checklists which include recommended preventive care and suggested actions to support patient use of that care.

Based on the identified gaps in care, medical assistants initially contact patients to discuss the need for preventive screenings and routine care, such as cancer screenings and tests for abnormal blood sugar or cholesterol levels. When patients arrive at their scheduled visit, a doctor, medical assistant or nurse reviews the pre-visit discussion and provides additional information based on physician recommendations. Following their appointment, patients are provided with an after-visit summary, patient education materials, prescription refills as appropriate, and follow up appointments are scheduled. Clinical care teams can determine whether members are adhering to their prescribed medication by analyzing refill trends.

From the clinical care team side, improvements in quality outcomes are encouraged through reward programs that provide bonuses when regional and annual goals are met. This system encourages cooperation and collaboration among many care providers. Care teams are encouraged to turn each patient encounter into a "successful opportunity" to increase appropriate use of preventive and basic care. Success is measured not by how many people are scheduled or referred for screenings, but based on how many patients actually get the recommended screening. "Successful opportunities" now account for 10 percent of the total bonuses available to care providers.

Outcomes:

Enhanced teamwork and partnerships between medical support staff and providers in applying this integrated and coordinated care delivery process has resulted in a positive impact on the lives of members in areas of cancer screening, blood pressure control, cardiac health, diabetes, asthma management, immunizations, tobacco cessation, weight management and exercise.

Kaiser Permanente's Southern California region has improved disease screening and treatment rates, which lower long-term health costs by preventing or successfully managing problems. Most importantly, these improved health outcomes save lives.

Along with other concurrent improvement initiatives, the POE has contributed to a 30 percent increase in colon cancer screenings, an 11 percent increase in breast cancer screening, five percent increase in cervical cancer screening, and a 13 percent improvement in cholesterol control.

Cost savings and cost impacts were not quantifiably measured; however, the impact on cost reduction relative to improvement in patient health and wellness could potentially be measured in the long term (decreased visits, readmission and mortality for example).

POE has also had a positive impact on Clinical Strategic Goals results:

Clinical Strategic Goal	2006	2007	2008
Breast Cancer Screening (Ages 52-69)	85.6	88.1	88.7
Cervical Cancer Screening	82.0	85.6	86.6
Colorectal Cancer Screening	52.5	65.5	69.7
LDL-C screening (CVD patients)	93.6	95.5	95.3
Controlling High BP (Ages 18-85)	70.4	72.8	79.6
HbA1c testing (Diabetes)	88.8	90.8	91.2
Eye exam (retinal) performed (Diabetes)	61.6	56.3	66.5
Lipid screening performed (Diabetes)	88.6	91.0	90.4
Nephropathy monitored (Diabetes)	92.5	94.0	93.7
Blood pressure control < 140/90 (Diabetes)	76.1	74.0	79.5
Influenza immunization rate (members 65+) ¹	60.2	62.0	62.0
Advised Smokers to Quit	53.0	63.0	67.0
Offered Strategies or Meds	35.0	43.0	49.0

Transportability:

POE can be easily transferred to other Kaiser Permanente Regions and be embedded in the culture and processes of care. This can be accomplished with modification of training materials and presentations provided, sharing KP HealthConnect functionality and Smart Tools, and providing copies of the POE video, patient recorded success stories, workflow videos, job aides, and reference sheets. Optimal integrated care at every patient encounter can now be a reality that leads to improved health throughout Kaiser Permanente and be the model for health care delivery across the Nation.

The project's impact has been wide spread and positive. It has changed the culture of the organization and provided a powerful tool for staff, physicians, and members. Proactive Care is now an expectation of care delivery. Like any new process, the implementation of POE experienced barriers in its implementation. These barriers were addressed in conjunction with labor partners, physicians, and leaders. Barriers consisted of resistance to change, fear of the unknown, concerns about adding work to the process, and concerns about job duties and scope of practice. These were addressed through education, communication, and site visits, as well as through elbow to elbow interaction and discussion.

Transferability

There is a clear advantage to implementing POE. It fits well with the Kaiser Permanente values for accountability, innovation, flexibility, quality, results, service, and partnership. Some of the benefits include improved clinical outcomes, increased work efficiency, enhanced work experience, and enhanced patient experience.

POE is in the process of being replicated in other Kaiser Permanente Regions and has been shared at many inter-Regional meetings including the National Quality and Brand Conference. In addition, there is much external interest, including community clinics in SCAL, as well as professional and National organizations. POE was presented at The Institute of Healthcare Improvement (IHI) meeting in Vancouver and was also presented at their National meeting in

December 2009. Recently, through the optimization process for POE, POS (Proactive Office Support) for patient messaging has been joined to the process to provide a more comprehensive and robust process. Through this process, standard workflows, tools, and job aides were developed and are available as a toolkit for training and deployment (attached). Programs interested in implementation have the ability to visit SCAL to evaluate the process and participate in discussion about the tools, processes, and deployment.

Summary:

In 2007, Kaiser Permanente Southern California piloted and rolled out the POE program. POE provides a highly reliable set of processes, tools and workflows for all patient-initiated interactions (face-to-face, telephone message and email) and is designed to support improvements in clinical quality, the care experience, access, and affordability.

The program leverages the skills of back office support staff to identify gaps in care before, during and after an encounter by designating specific tasks for each part of the encounter. Clinicians and support staff utilize tools and SmartSets available via KP HealthConnect and to address individual patient's needs.

These early results illustrate how coordinating activities between various health providers throughout the care delivery system, and equipping caregivers with real-time information, can support patient care and improve outcomes. Maximizing information for the clinician means optimizing care for the patient. Done well, a computerized system supports clinicians' efforts to spend more time with patients, have better information about their care and spend less time with traditional paperwork.

The project supports a cultural shift in the way care is provided for members. This shift (proactive, planned, and systematic care delivery) touches all aspects of the organization and impacts members in a positive manner by activating them in their care.

The care experience shifts from one that is traditionally reactive to one that is planned, proactive, and systematic. It is innovative in that it is designed to operate in a way that is not dependant on an individual's ability to remember the steps or aspects of care needed. Rather, the process provides reliable evidence-based systemic solution to care delivery. In addition, this design ensures patients receive preventive care and chronic care at each visit, including specialty care visits. It supports this care at each encounter by each care giver.

In the near future, Southern California intends to implement the POE process in the pharmacy and inpatient hospital setting. Deployment of POE in the emergency departments and urgent care settings is already in progress.

Figure 1: Roles and Responsibilities Administrative Tool

Area Medical Director

- Actively promote the POS/POE program to the Department Administrators, Chiefs and Physicians.
- Stress the importance of the Physician Survey as a key tool to improve In-Basket and Module support.
- Review the local strategies and quarterly performance with the MGA and Area Proactive Care Lead.
- Assign Physician POE/POS champion.

Medical Group Administrator

- Understand the vision, goals, and high level processes of POS/POE.
- Actively promote and champion POE/POS to the administrative team.
- Review POE/POS performance results: Monthly TAT report, physician survey results, POE utilization rate and successful opportunities report.
- Partner with the Area Proactive Care Lead, Project Manager, and Work Flow Consultants to develop the implementation, monitoring, and performance improvement processes.
- Review Proactive Care metrics and performance improvement process with the AMGA/Area Proactive Care Lead on a monthly basis.
- Meet with physician groups periodically to obtain feedback on the quality of in-basket and module support.
- Provide periodic feedback to the Department Administrators regarding POE/POS performance.
- Work with the AMGA/Area Proactive Care Lead to develop an accountability process for improving physician support based on Proactive Care metrics.

Assistant Medical Group Administrator / Area Proactive Care Lead

- Champion the vision and goals of POS/POE to Department Administrators.
- Understand the basics of the Standard Work Flows for In-Basket and Module support.
- The Proactive Care Project Manager, KP HealthConnect SIM, and Work Flow Consultants should report to the Proactive Care Lead regarding the plan for the training and skills validation process.
- Oversee the implementation and performance improvement process in collaboration with the Proactive Care Project Manager.
- Review POE/POS performance results: un-blinded monthly TAT report, physician survey results, POE utilization rate and successful opportunities with Project Manager and Department Administrators.
- Have an accountability process for under performing Department Administrators.
- Meet with physician groups to get feedback on how in-basket and module support is progressing.
- Participate in regional meetings to share best practices.

Proactive Care Physician Lead

- Actively promote the vision and goals of Proactive Office Support and Proactive Office Encounter to leadership groups and local physicians.
- Work with DAs and Chiefs to help them understand the vision of Proactive Care, training, implementation and performance improvement processes.
- Work with the Area Proactive Care Lead, Project Manager, and Work Flow Consultants to develop a strategy for deployment and optimization.
- Participate in regional meetings to share best practices.

Proactive Care Project Manager

- Actively promote and champion POS/POE in-basket and module support process.
- Collaborate with the Area Proactive Care Lead to develop a deployment schedule and logistics in conjunction with the Work Flow Consultant.
- Oversee the administration and collection of the physician survey and forward the surveys to the region.
- Work with Proactive Care Leader on the implementation plan for the Medical Center.
- Provide support on the utilization of automated POS/POE Audit Surveys.
- Review the Proactive Care Metrics and provide assistance to the DA to improve performance.
- Communicate regional updates via newsletter to all departments.
- Compile executive summaries for senior leadership on Proactive Care performance.

Work Flow Consultant

- Actively promote and champion POS/POE in-basket and module support process.
- Work with specialty leaders to assist with the development of specialty specific work flows.
- Work with each DA on the implementation plan for the department.
- Train standard and specialty specific work flows to all specialty "content experts" (RN, LVN, MA).
- Train the standard and specialty specific work flows to all Long Term Support staff so they can support the training of staff in all departments.
- Provide DA training on the Workflow Efficiency Report and Manual Workflow Audit.
- Support the training efforts for each department: Group training initially followed by focused training for staff with performance gaps.
- Support all departments in the skills validation and skills optimization process.
- Provide consultative support to DAs and Chiefs to identify and remedy work flow issues identified by the DA/Chief or the Proactive Care metrics.

Long Term Support

- LTS should be divided up and assigned to specific departments to facilitate rapid deployment and training of staff in all departments.

- Develop a working understanding of standard and specialty specific work flows for their assigned depts.
- Train standard and specialty specific work flows to specialty content experts (RN, LVN, MA) in collaboration with work flow consultants.
- Support the training efforts for each department: Group training initially followed by focused training for staff with performance gaps.

Chief of Service

- Understand and promote the vision and goals of the Proactive Care in-basket and module work flows.
- Work with department physicians to develop specialty-specific in-basket and module work flows.
- Collaborate with the Department Administrator, KPHC SIM, and Project Manager regarding the training schedule and implementation strategy for each department.
- Stress the importance of the Physician Survey as a key tool to improve in-basket and module support.
- Regularly review department's performance with the DA and discuss strategies to improve performance.

Department Administrator

- Promote the vision and goals of the standard and specialty specific POE/POS work flows to all staff.
- Collaborate with department Chief and Physicians to understand gaps in module and in-basket support and develop policies and work flows to improve performance. Collaborate with the Work Flow Consultants to implement these work flow changes.
- Collaborate with the Proactive Care Project Manager, KPHC SIM, and Work Flow Consultants to develop a schedule for training and skills validation on the standard work flows for in-basket and module support.
- Identify departmental staff RNs, LVNs, and MAs who will serve as "content experts."
- Assign personnel to administer and collect the physician survey. Forward surveys to the Project Manager.
- Review un-blinded data with staff and develop a performance improvement plan for poor performance.
- Round periodically with the department Chief to assess progress and gaps in POE/POS support.
- Review Proactive Care data with the department Chief and discuss strategies to improve performance.
- Use a Rapid Cycle Feedback process to provide staff with timely information regarding performance.
- Work with Work Flow Consultants, LTS, and "content experts" to remediate skills gaps based on Proactive Care metrics and physician feedback.
- Schedule and execute one on one team agreements between providers and staff.
- Audit of five charts per staff member per month for staff providing in-basket phone support.
- Manually audit charts using the POE chart audit tools and provide feedback to staff.
- Collaborate with LTS and Work Flow Consultants to arrange skills validation training for all staff.
- Develop an accountability/corrective action process for under performing staff.

Figure 2: Proactive Care Readiness Checklist Administrative Tool

<p>Area Readiness</p> <p>Vision, Roles and Responsibilities</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Key Stake Holders Identified: <ul style="list-style-type: none"> - POS/POE AMGA or Area Lead - Proactive Care Physician Lead - Project Manager - SIM, LTS, Work Flow Consultants <input type="checkbox"/> Setting the Vision – Meet with Department Administrators & Chiefs to present the vision, roles and responsibilities, standard work flows and the goals of Proactive Office Support and Proactive Office Encounter. <input type="checkbox"/> Setting the Vision – Meetings with local physicians to present the vision and standard work flows for in-basket and medical office/module support. <input type="checkbox"/> Standard Work Flow Tools have been reviewed with DAs and Chiefs. <input type="checkbox"/> Training Tools – Reviewed with LTS, Project Managers, Work Flow Consultants, and Content Experts. <input type="checkbox"/> Reference Tools – Reviewed with LTS, Project Managers, Work Flow Consultants, and Content Experts. <input type="checkbox"/> Monitoring Tools and Process have been reviewed with DAs, Project Managers, and Work Flow Consultants. <input type="checkbox"/> Performance Improvement – Physician survey reviewed with DAs, Chiefs, Project Managers, and Physicians.
<p>Departmental Readiness</p>	<ul style="list-style-type: none"> <input type="checkbox"/> In-Basket support staff identified and trained on Standard Messaging Guidelines. <input type="checkbox"/> Departmental RN, LVN, MA HealthConnect “Content Experts” identified. <input type="checkbox"/> Setting the Vision – Vision for In-Basket Support and Standard Module Work Flows presented to Department Staff. <input type="checkbox"/> Work Flow – Specialty Specific Module (POE) Work Flows <u>Developed</u> by Physicians, Chief, and DA. <input type="checkbox"/> Work Flow – Specialty Specific Module (POE) Work Flows <u>Presented</u> to RN, LVN, and MA Staff. <input type="checkbox"/> Reference Tools – Reviewed with Staff and Content Experts (Local “Red Flags” and Smart Tools Reference Guide). <input type="checkbox"/> Monitoring Tools (POE/POS Audit, Chart Review Tool) and Process understood by DA and Chief. <input type="checkbox"/> Performance Improvement – Physician survey reviewed with Physicians and Staff. <input type="checkbox"/> Training and skills validation schedule developed in coordination with SIM, LTS, and Work Flow Consultants. <input type="checkbox"/> Physician Survey: Individual identified who will administer and collect physician survey (Admin Specialist, DA, or ADA) <input type="checkbox"/> Physician survey schedule developed. Initial (Pre Deployment) then every 2 months. <input type="checkbox"/> DA and Chief understand rounding and rapid cycle feedback process. <input type="checkbox"/> Process developed to provide staff feedback from the physician survey results and POE/POS audit data.
<p>Training Readiness</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Training Location(s) identified. <input type="checkbox"/> Training Tools Acquired: Videos on CD and Job Aids. Standard and specialty specific work flow docs laminated. <input type="checkbox"/> Training Process Identified: Computer lab with follow-up process including “elbow to elbow” training by Content Experts, LTS, and Work Flow Consultants. <input type="checkbox"/> Trainers reviewed the training videos, job aids, reference guides and standard and specialty specific work flows.
<p>Implementation</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Implementation schedule developed: Primary Care (APC, Peds, OB/GYN), Medical Specialties, and Surgical Specialties. <input type="checkbox"/> Implementation steps reviewed with DAs and Chiefs.
<p>Monitoring</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Project Manager – Developed a process to oversee training, implementation, monitoring and improving performance.

- Project Manager – Developed a process to provide feedback on ASQ Scores, POE/POS Audit Data.
- Project Manager – Process developed for oversight of administering and collecting physician surveys.
- DA's have been trained on the use of the POE and POS Audit Tool, Chart Audit Tool, and Rounding Tool.

**Performance
Improvement**

- MGA/AMGA - Process in place for providing feedback to DAs.
- MGA/AMGA - Accountability process developed by MGA and AMGAs.
- Process for performance improvement and expectations for rounding and acting on data reviewed with DA's.
- MGAs, AMGAs, POS Leads, and DA's have reviewed work flows for improving quality and turn around time.
- MGAs, AMGAs, POS Leads, and DA's have reviewed lessons learned on practices that deteriorate performance.