

Riverside Proactive Health Management (RiPHM):
A Comprehensive Approach to Prevention and Chronic Disease Management

Program Description

The “Chronic Care Model” developed by Ed Wagner, MD, director of Improving Chronic Illness Care (ICIC), a national clinical quality initiative was adopted by Kaiser Permanente (KP) Care Management Institute. The model and its description have been modified by KP Southern California Population Care Management.

Riverside Medical Center implemented key elements of the model in late 2000. Population Care Management (PCM) and Clinical Quality programs were integrated in primary care to support the physician practice. Population Care Nurse Clinics (PCNCs) were created to provide clinical management and member outreach activities for members with chronic conditions.

In 2003, Riverside Medical Center implemented the **Riverside Proactive Health Management Program**, an integrated Population Care Management (PCM) model of care to strengthen the “medical home” concept and identify members of the Health Care Team (HCT). Multi-disciplinary teams- staff that are centrally directed and physically located in modules provide panel management activities and comprehensive in reach/outreach functions to support primary care physicians proactively manage the health care of members with chronic conditions such as Diabetes, Hypertension, Cardio-Vascular Disease (CVD) and Asthma and members who need preventive screening. Additional programs for preventive screening include Osteoporosis and Depression Care Management, Colon Cancer and Cervical Cancer.

In 2005, functions of the HCT were expanded to include activities focusing on behavior modification and self-management. Tools for medication adherence and action planning were implemented.

In mid 2006, the LVN Health Care Coach Program was started in PCM to enhance the patient care experience and address missed opportunities. PCM staff identified future appointments and using scripted outreach messages. They informed and activated patients to address care gaps such as need to obtain glucose meter for Self Monitoring of Blood Glucose (SMBG), obtain more recent Diabetes and CVD labs, arrange Pap smear appointments, etc. Key components of the program were implemented at KPSC through Pro-Active Office Encounter (POE).

RiPHM has been implemented across the service area and in all Medical Office Buildings (MOB’s) with active participation of all primary care physicians from Internal Medicine, Family Medicine and Residency Programs. Currently, enhancements to the model are being made to strengthen module staff interventions during office visits by defining more active and specific roles of MA’s, LVN’s and RN’s in all areas including specialty departments through POE and use of KP Health Connect tools.

Through the model of care, Riverside Medical Center’s health care delivery system, has sustained performance on key quality measures as indicated in KPSC Regional Clinical Strategic Goals (CSG) Reports. NCQA Diabetes Physician Recognition Program has awarded accreditation to 213 physicians, statewide, 187 of which are Kaiser Physicians, 25 of those are from Riverside.
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Goals and Implementation Objectives

Riverside Medical Center seeks to provide Complete Care by facilitating preventive screening and coordination of intervention for patients with chronic conditions in the ambulatory setting and across the health care continuum. The objective of this model is to improve health care outcomes for Riverside is members and to sustain medical center performance on key quality indicators.

Targeted Populations

Diabetes, Cardio-vascular Disease, Hypertension, Heart Failure, Asthma, Osteoporosis, Depression, Colon Cancer Screening, Cervical Cancer Screening, and Breast Cancer. Patients targeted for Smoking Cessation Programs
Key Components

A. Population Care Management and Population Care Nurse Clinic (PCNC)

- **Population Care Nurse Clinic (PCNC)** provides individual RN face to face nurse visits, telephonic follow-up and panel management support. Senior level RNs located in the main campus and outlying MOBs provide:
  
a. **Face-to-Face, 20-minute Office Visits (60%)**:
    - Diabetes Care Management: for member education to improve self-management skills through: glucometer teaching, self-monitoring of blood glucose and utilization of the self-titration algorithms (Treat to Target). At the RN visit, interventions include: action planning, assessment of “readiness to change” and medication adherence. Members are screened for depression using the PHQ-9 tool and yearly Diabetes assessment is completed.
    - Hypertension Care Management- Using Hypertension Treat to Target treatment guidelines, RN’s provide medication management and member education to a targeted group of patients with uncontrolled BP.
    - Heart Failure (HF) and Resource Intensive Members (RIM) - follow up of patients for education and medication adherence who were identified in the Regional Transitional Care and Tele-monitoring Programs. Expanded to include coordination of care for members discharged from the hospital for targeted population identified as RIM.
  
b. **Panel Management Support and Telephonic Follow-Up (40%)** - working in collaboration with the members of the HCT, RNs review KPHC medical records to identify paneled patients with care gaps that will be targeted for outreach and seen at PCNC.

- **PCM Based Comprehensive Outreach Programs**: Using information systems such as POINT, and KPHC patients with care gaps are outreached by clerical staff through telephone and Kaiser Permanente Notification System (KPNS). Diabetic members are evaluated if they meet the following criteria: no recent primary care visits, missing labs, no glucometer /strip renewals, missing retinal photos, or if goals for CSG initiatives are not met, i.e. lipid control, microalbumin, A1C or Blood Pressure control, smoking cessation, etc.

- **Proactive Panel Management**

  a. **Panel Management Process workflow** Through a centrally coordinated Population Care Management program that draws on a centralized database system maintained for the target populations, RNs and LVNs provide clinical management and member outreach activities for members with chronic conditions. Centrally directed RN Care Coordinators review care gaps and treatment plans with individual PCPs to obtain verbal orders which are then carried out by populating electronic information into KP.
HealthConnect (called the panel support review tool – an electronic worksheet for individual patient data). Physician routes orders to PCM or module-based staff. MAs and LVNs provide additional and supplementary proactive in reach and outreach activities through the Pro-Active Office Encounter (POE). The target group of patients is provided to the Cholesterol Management Ambulatory Pharmacist for active lipid management.

b. **PCM Physician Dedicated Time and Panel Support.** Primary care physicians are provided PCM time (40 mins per MD per month) to review KPHC medical record of paneled patients with chronic conditions routed to them through PCM Panel Management. Education Time (ET) is also utilized to work on treatment recommendations provided by PCM.

c. **Health Care Coach Program:** LVNs trained in self-management and telephonic outreach provide the following activities:

   - **Day of Visit:** POE interventions to engage and activate the patient to establish a plan of action for yearly labs and complete retinal photographs, re-fill medications and testing strips for patients seen at PCNC. Pre-visit Interventions for Primary Care Departments were transitioned to module staff through Pro-Active Office Encounter (POE) Program.

   - **After Visit (PCNC and PCP) -** Follow up of patients seen in PCNC for self management, medication adherence, action planning and documentation of blood glucose monitoring. For a select group of primary care physicians, Using scripted messages; LVNs provide telephonic follow-up to address medication adherence and self-management.

d. **Staffing** 112 PCPs across the Riverside Service Area: one Main Campus with primary care (Internal and Family Medicine) and specialty care services and four additional facilities are supported by six RNs, six LVNs, and three clerical staff (all centrally directed). Panel management activities are also divided up and coordinated in part by module MA and RN staff that support individual PCP’s in their daily practice.

e. **Roles and Responsibilities for Panel Management** (see appendix A)

f. **IT tools:**

   - POINT Panel Management and Care Management Tools (Web-based registry system)
   - Care Management Summary Sheets (CMSS) populated in KP HealthConnect and Best Practice Alerts.
   - PCM Future Appointments Database
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- POINT Proactive Office Encounter Tool

B. Diabetes Care Management

Diabetes care at Riverside is a comprehensive program that includes multidisciplinary, seamless care for members with chronic condition. Care is integrated into primary care and specialty care physician’s practice and is delivered across the health care continuum including ambulatory, inpatient, peri-operative services and home care. The Diabetes Advisory Board (DAB) provides oversight to the program. Comprehensive Diabetes care include: from Endocrinology, Department Diabetic Team Care Clinic (DTCC): Insulin Pump Clinic and Diabetes Resource Center (DRC). Other medical center programs for the Diabetic Population: Exercise Program, Gestational Diabetes Program, Limb Salvage Diabetic Ulcer Clinic, DIGMA (Drop in Group Medical Appointment) and Peri-operative Program for Diabetic Patients, Member Health Education, Latino Support Group.

C. Cholesterol Management

Cardiovascular patients are identified in POINT Registry. PCM provides centralized outreach activities for missing labs and telephonic medication management by a Pharmacist to achieve LDL goals for the patient. These activities are tracked and integrated in panel management.

D. Medication Adherence and Management Program

PCM, in collaboration with Pharmacy Operations have developed comprehensive educational programs for staff and member education to promote medication adherence. Consideration to health literacy and cultural competence are being integrated in member education materials and outreach efforts. Member communication through phone scripts and used in automated systems such as Interactive Voice Recognition (IVR) are being utilized to promote member engagement and self-management.

E. Complex Chronic Condition Care Management and RIM

- **Heart Failure /Diabetes Tele-monitoring Program:** Using state of the art tele-monitoring device, a Pharmacy Care Manager is able to provide telephonic care management on a daily basis. Daily blood glucose is provided to the Care Manager in addition to other parameters related to Heart Failure. Through behavior modification, patients are encouraged to alter daily activities and medications are adjusted. Program will continue with Regional Innovations Funding.

- **KP Mobile Wellness:** In 2007, Kaiser Permanente Riverside began a pilot test of a tool to management chronic care. The program was initially rolled out to high-risk patients with diabetes. The goal of this program is to achieve better blood sugar control among patients and therefore, better patient outcomes by increasing patient/medical team communication, raise patient compliance with
treatment such as behavioral change, and provide daily tracking of patient status. Using cellular phone technology, high-risk patients are able to use text and picture messaging feature to facilitate exchange of medical information between the patient and medical care team. Patients enter information such as their blood sugars into the phone and the data is sent to a server and reported via a website to providers. The patients’ medical team is then able to communicate back to the patient with either automatic or specific messages based upon preset parameters.

- **Population Care Management Clinical RN Coordinator, Inpatient** is responsible for identifying members with chronic conditions. Member education and coordination of chronic condition care between inpatient and ambulatory care setting. The RN conducts inpatient rounds, reviews inpatient census to establish a care plan including ambulatory care follow up and referral to Care Management such as Heart Failure Clinic, etc.

**F. Comprehensive Screening Programs**

Multi-disciplinary teams from primary and specialty care departments participate in workgroups that are facilitated by a physician champion and an administrative leader to develop strategies to improve screening programs and address access for treatment and follow-up of members.

- **Osteoporosis Care Management:** Osteoporosis intervention was developed to address the need for both timely screening and intervention to improve patient care. Hip-at-Risk (HARP) utilizes a Point-System database which generates a list of patients 65 years of age or older who meet HEDIS definitions of at-risk. Eligible population is outreach and encouraged to obtain DEXA scan. Depending on results, members are seen in PCNC where education is started and medications are initiated.

- **Depression Screening** Riverside’s program aims to provide depression screening for patients with chronic conditions, specifically CVD patients. PHQ-9 questionnaires are used for group appointments, team care clinics, PCNC RN visits. Depending on scores, behavior modification interventions are provided by PCM staff through telephonic management and face to face visits are scheduled with a Licensed Clinical Social Worker trained to provide Level II Depression intervention.

- **Breast Cancer Screening** Beginning in 2002, Mammography outreach and in reach medical center interventions were implemented to increase the number of screening mammography procedures for female Health Plan members ages 50 – 69. Program was enhanced to include the “Timely Diagnosis of Breast Cancer Project” which aims to reduce the days wait time from suspicion of a suspected abnormality to diagnosis of breast cancer from a baseline of 32% diagnosed within 14 days to a target of 80% diagnosed within 14 days or less by year-end 2004.
• **Colo-rectal Cancer Screening.** In 2006, the Riverside Colorectal Cancer Screening Task Force was formed to develop strategies and initiatives to improve the quality of life of our members by decreasing the number of members diagnosed with colon cancer. The task force consists of multi-departments with ownership driven by physician, administrative, and project management leadership. The team works collaborative and effectively as a team by wanting to be the leader in the region. They have educated staff and providers to capture unscreen colon cancer members at the point of service and developed an outreach program that was adopted by Southern California Region Offices to centralize outreach for the entire region.

• **Cervical Cancer Screening** In 2006, the program was developed to implement comprehensive in reach and outreach efforts to provide cervical screening for Health Plan members ages 18 -64 who are eligible for the screening. Primary care and OB/Gyn Departments work collaboratively to provide access to appointment for screening.

• **Hypertension (HTN) Screening and Care Management.** Initially implemented in PCM Nurse Clinic. BP evaluations and treatment were initiated by RN’s and LVN’s. Providers from specialty care referred to the program through a Hypertension Hotline. Program has been transition to primary care. HTN follow up now resides in primary care departments and PCP’s.

• **Smoking Cessation Program.** Facilitated by Health Education Department which involves the following activities: physician and staff education on smoking cessation, provision of a hotline for patients to call, monitoring of medical center performance related to smoking: advise to quit and starting medications, member education and reminders through Kaiser Permanente Notification System (KPNS) of patients seen in Internal Medicine and development of DVD for staff education.

G. Performance Reporting and Measurement

In 2003, physician, department and module specific data on performance were developed to provide feedback to PCP’s and Chiefs of Service on individual pcp and medical center performance. Using KP legacy systems, data was obtained through 4-D, a home grown database that tracks performance. Similar program is now available through POINT Performance Measurement Tool. Regional reports such as CSG Bi-Monthly reports were also evaluated for performance improvement efforts.

H. Continuous Quality Management

Beginning 2007, activities to improve performance on CSGs were integrated in department specific Performance Improvement (PI) plans which are being measured through Continuous Quality Improvement (CQI) programs jointly developed by PCM and Quality Management. Department specific patient care goals have been identified and data collection tools were developed to monitor physician activities. Information will be included physician Quality and Re-Credentialing profiles.
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Outcomes data is reviewed and reported at all levels including the Medical Center Executive Committee. The Performance Improvement Committee (PIC) provides oversight of medical center performance.

I. Physician and Staff Education

Medical center wide efforts on physician and staff education were launched in 2004 to raise awareness of quality initiatives. Venues for communication included: department meetings, leadership meetings for Department Administrators, Chiefs of Service, etc, Physician Roundtable, Skills Fair, Nursing Orientations, New Physician Enculturation Programs, etc.

J. Leadership and Accountability:

Medical center leaders provide oversight of the PCM and Riverside Quality Programs. Group is composed of PCM physician and administrative leaders, Assistant Medical Group Administrators, Assistant Medical Director, Chief of Service for Internal Medicine and Family Medicine.

Riverside’s Proactive Health Management Program has encouraged a culture of accountability among primary care physicians and the ancillary staff as it established the “medical home” for the patient and built an infrastructure to support quality patient care. Through the support of medical center senior leaders, the program continues to expand beyond primary care and now includes participation of specialty care physicians and department administrators. The centralized PCM program that facilitates most of the activities is comprised of ancillary staff (RN’s, LVN’s and clerical staff) and focus on improving care for patients with chronic conditions.
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References:

Pro-Active Panel Management Roles and Responsibilities

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<tr>
<th>Care Coordinators, RN</th>
<th>PCPs:</th>
<th>RN – Population Care Nurse Clinic</th>
<th>LVNs, Health Care Coaches</th>
<th>Administrative Specialists</th>
<th>Module RNs and MA’s</th>
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<tr>
<td>With direction from Population Care Management (PCM) Leaders and PCPs, RNs</td>
<td>Are allocated two 20-minute appointment slots per PCP per month (totaling 40 minutes). Each PCP reviews information on approximately 25-30 patients per month (those patients not presenting for an office visit). During designated panel management time, PCPs: review individualized electronic patient information KP HealthConnect records and pending orders from PCM staff; make clinical decisions for treatment; direct PCM activities for patients in their panel.</td>
<td>Physically located in MOB’s, reports to PCM and are responsible for:</td>
<td>Physically located in MOB’s and are responsible for:</td>
<td>Based in Primary Care Depts</td>
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<td>- determine priorities for panel management activities</td>
<td>- provide oversight and clinical management across continuum of care for chronic condition patients;</td>
<td>- One-on-one clinic appointments to evaluate and assess medical condition through initial assessments and triage</td>
<td>- Identify future appointments and use scripted outreach messages; inform and activate patients, i.e. need to obtain glucose meter for self-monitoring of blood glucose (SMBG), obtain more recent diabetes and CVD labs, arrange pap smear appointments, etc;</td>
<td>- Support the PCPs in their daily practice and take responsibility for carrying out orders in panel management such as calling patients for medication changes or lab orders as directed by the PCP;</td>
<td>- For PCNC Appointments and Care Management visits (e.g. CHF Clinic), schedule patients with no recent office visits, have missing labs, not refilling glucometer strips, and have A1c levels out of control.</td>
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<td>- provide oversight and clinical management across continuum of care for chronic condition patients;</td>
<td>- educate front-line staff/departments re: Clinical Quality and PCM initiatives</td>
<td>- Conduct medical record review using KPHC tools (Proactive Panel Support) and recommend treatment suggestions for primary care physicians for Diabetes Treat to Target (TTT).</td>
<td>- Hypertension population seen in specialty care departments</td>
<td>- Participate in outreach efforts for hypertension by providing nurse visits for blood pressure checks. RN’s trained on insulin starts and initial member education.</td>
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<tr>
<td>- review treatment guidelines and recommendations, in addition to lab tests, relevant lab data, medication history for patients;</td>
<td>- based on clinical assessment, recommend plan of care and intervention on compliance and medication adherence</td>
<td>- Arrange services with PharmD and other health care providers such as Health Education, etc.</td>
<td>- Osteoporosis patients with completed Bone Density results</td>
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<td>- Retrieve orders from PCPs &amp; disseminate (divide the work among different staff) these to appropriate team members including centrally managed staff and staff located in the modules.</td>
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**Pro-Active Panel Management Roles and Responsibilities**