Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
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Reinsurance Program Carrier Accountability Report – Narrative[1]
Plan Year (PY) 2019

Kaiser Permanente (KP) is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia. Kaiser Permanente of the Mid-Atlantic States (KPMAS), which operates in Maryland, provides and coordinates complete health care services for approximately 755,000 members. In Maryland, we deliver care to over 430,000 members.

In 2019, KP undertook the following initiatives to manage the costs and utilization of enrollees whose claims were reimbursed by the State Reinsurance Program (SRP) in PY 2019.

Name of the Initiative: **Diabetes – Care Management Program**

A. **Population(s) Targeted by the Initiative and How They Are Identified:** Members who have Type 2 diabetes and an A1c result of >7.9% (poor glycemic control) and are referred by their physician or through outreach by the care managers based on a centralized report identifying qualifying members.

B. **Description of the Initiative:** The Care Management Program (CMP) is comprised of a coordinated team of pharmacists, registered nurses and nurse practitioners that provide panel-based care for KPMAS' members with poor glycemic control (A1c ≥8.0%)[i] under the clinical leadership of the Mid-Atlantic Permanente Medical Group (MAPMG) Population Care Management Physician Director and Director. Patients enter the program through physician, case management, or other care provider referral, CMP staff case finding through panel management systems, and/or auto-enrollment based on prior laboratory results. Care managers work in collaboration with the patient and the patient's primary care physician to determine the patient's goals and therapeutic intervention plans. During weekly touchpoints with the care manager, predominantly through phone or secure e-mail message, patients receive self-management skill-building, diabetes education, lifestyle management, and diabetes medication titration (by protocol or in collaboration with the primary care physician) to reach their goals. Documentation and communication are conducted through the Kaiser Permanente HealthConnect (KPHC) electronic medical record to ensure coordination of care between CMP staff and other care providers. KPHC decision support and technology-based tools support patient management and tracking and Tableau reporting supports management in tracking and monitoring staff process and outcomes metrics.

C. **Intended Goals and/or Outcomes of the Initiative:** Initiative goals are to provide interventions to members to help them improve their glycemic control as measured by A1c results, typically within 12 weeks although members may continue until their individual goals are met.

[1] This report includes the narrative portions described in B.1, B.2.2, B.4, and B.5 in the instructions for the SRP Accountability Report.

D. **Activities Undertaken to Evaluate the Effectiveness of the Initiative:** A weekly updated tableau dashboard demonstrates the impact of the program based on number of members who have reached goal as a program and by practitioner and are trended over time.

E. **Methodology for Determining the Initiatives to Include in this Report:** Identified initiatives that addressed the chronic condition/topic in a meaningful way to improve the health of the population and that impacted a large percentage of the population.

F. **Efforts to improve outreach, recruitment, and retention in these programs:** KPMAS continually innovates to help engage more members in the programs. Through outreach by physicians to members who may benefit from the initiative, to weekly reports sent to the care managers to contact eligible members and request they engage in the program, to secure message outreach to eligible members, new strategies are introduced often. An advantage of the weekly contact is that retention tends to be strong and until a member asks to leave the program, they will continue receiving contacts by the care managers.

G. **Changes to the intervention strategy:** While the core model of weekly touch points has not changed, over time there have been adjustments to the engagement, outreach, intervention timeline, and reporting.

H. **Development of any new initiatives:** An at-home glucometer telemonitoring program was initiated in late 2019 to support the care managers and members ability to manage their diabetes.

I. **Other actions:** N/A

Name of the Initiative: **Diabetes – Educational Video**

A. **Population(s) Targeted by the Initiative and How They Are Identified:** Members who have Type 1 or Type 2 diabetes and a prior A1c result of >7.9% (poor glycemic control) or who did not have an A1c test for glycemic control in the prior 10 months.

B. **Description of the Initiative:** A secure message email was sent to members that included a link to an educational video by one our physicians providing information on the importance of managing diabetes and staying up-to-date on care. Creating and using a video produced by our team and physicians ensured that the message was aligned with our overall program, health education materials both online and distributed as part of an office encounter, and helped to engage members in a more personal way by using a Permanente physician to deliver the message of caring for one's health and staying up-to-date. The secure message and/or video included links to resources and promoted self-management skill building programs, such as the classes and care management program. The message also encouraged a visit to the laboratory to track a member's A1c results to determine their glycemic control. The message encouraged members also to review a blog post about healthy holiday meals, Members whose spoken language preference is Spanish received a secure message in Spanish and a video recorded by a native Spanish speaker.

C. **Intended Goals and/or Outcomes of the Initiative:** Initiative goals are to provide education, motivation and reminders to members to help them improve their glycemic

control as measured by going to the laboratory to get an A1c test and to demonstrate a A1c result at the goal of < 8.0%.

D. **Activities Undertaken to Evaluate the Effectiveness of the Initiative:** The impact of the initiative was measured by the number of members who opened (proxy for read) the message, watched the video, went to the blog post web site, had an A1c test completed, and had an A1c test result at goal of < 8.0%.

E. **Methodology for Determining the Initiatives to Include in this Report:** Identified initiatives that addressed the chronic condition/topic in a meaningful way to improve the health of the population and that impacted a large percentage of the population.

F. **Efforts to improve outreach, recruitment, and retention in these programs:** KPMAS continually innovates to help engage more members in the programs and for 2020, the videos will be reproduced for a more tailored audience, for example, based on cultural experiences and/or demographics, such as age.

G. **Changes to the intervention strategy:** For 2020, the secure message will be further tailored to a member's age and/or gender and more culturally tailored messaging.

H. **Development of any new initiatives:** KPMAS continually innovates new approaches to managing diabetes and engaging members into the process.

I. **Other actions:** N/A

Methodology for Calculating Savings to the SRP

KP used the following methodology to estimate the savings to the SRP as a result of these initiatives:

1. Identified enrollees with claims reimbursed by the SRP in PY 2019 who have participated in the 2019 Diabetes Initiatives.
2. Population was then limited to enrollees who were active for more than 7 months of years 2018, 2019, and 2020.
3. The difference in spend between years is considered the estimated savings.