Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

Reinsurance Program Carrier Accountability Report – Narrative[1]
Plan Year (PY) 2020

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 786,000 members. In Maryland, we deliver care to more than 500,000 members.

In 2020, 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 2020.

Name of the Initiative: **Diabetes – Glucometer**

A. **Population(s) Targeted by the Initiative and How They Are Identified:** Members who have Type 2 diabetes and a prior A1c result of >7.9% (poor glycemic control).

B. **Description of the Initiative:** Members who qualify for the program based on a readiness survey and who meet clinical criteria are provided a Bluetooth-enabled glucometer and instructions for using the app to support telemonitoring of their glucose levels from home. Members then upload their readings using the app that are then imbedded in the KP EMR and care managers and/or physicians review and monitor the results. Should modifications be made, the care manager and/or physician will coordinate with the patient and physician, as needed, to help ensure glucose levels are managed. Staff receive notification for patients whose readings are below or above a set threshold of concern and will contact the patient to ensure they are stable and to provide guidance.

C. **Intended Goals and/or Outcomes of the Initiative:** Initiative goals are to provide technological support and at-home telemedicine opportunities to facilitate the management of diabetes outside of the medical office building. This approach was particularly helpful in 2020 when the care delivery system required modifications to standard operating procedures to support the management of the COVID-19 pandemic.

D. **Activities Undertaken to Evaluate the Effectiveness of the Initiative:** A 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. For 2020, the benefit of telemedicine during the COVID-19 pandemic was a motivator for members to engage

[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.

not only in their diabetes care but also to leverage the benefit of managing their disease more closely outside of the traditional medical office visit.

G. **Changes to the intervention strategy:** None in 2020.

H. **Development of any new initiatives:** KPMAS continually innovates new approaches to managing diabetes and engaging members into the process. The process began with nurse care managers as the predominant caregivers but over time, both clinical pharmacists and primary care physicians have become engaged in managing the at-home results.

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

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. Although this program had fewer than 300 enrollees for 2020, it is an ongoing initiative. In 2020, staffing was modified for a few months while some staff were re-deployed to support changes to the care delivery system due to COVID-19 and therefore overall enrollment declined over prior years.

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. 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.

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 approaches to engagement are attempted, although the impact of the pandemic limited extensive new approaches in 2020. 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, especially

H. **Development of any new initiatives:** The necessity of managing the COVID-19 pandemic in 2020 limited the development of new initiatives in 2020.

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

Name of the Initiative: **Depression Care Management**

A. **Population(s) Targeted by the Initiative and How They Are Identified:** Members who have depression as determined by a PHQ-2 or PHQ-9 assessment completed during an office visit (in person or virtual) or an online questionnaire connected to the member portal, kp.org.

B. **Description of the Initiative:** The depression care management program begins with the identification of members with depression. In 2020, the program was expanded to identify members with depression more comprehensively through enhanced universal screening processes. In addition to members completing a PHQ-2 questionnaire during office visits (in person or virtual) as part of the rooming process, the program sent secure outreach email messages to members who had not completed a PHQ-2 depression screening in the past year. The email message included a link to the online questionnaire within the member portal, kp.org. A positive response to the PHQ-2 reflexes to the PHQ-9 questionnaire. From the PHQ-9 assessment that is automatically calculated, members are triaged into three possible options – mild, moderate, or moderate/severe depression. Members with mild depression are automatically sent resources to help them self-manage at home; members with moderate depression are connected with their PCP and members with moderate/severe depression are connected with a behavioral health clinician. Members may also enter the program through assessments by their clinicians as part of routine or problem-based care. Regardless, the PHQ-9 is used as the baseline tool to help establish a depression diagnosis and severity and is used to assess the success of the therapeutic intervention, whether counseling and/or medication. Either the primary care or behavioral health clinician will manage their care with the support of automated email reminder messages sent to members to request completion of the PHQ-9 to monitor their treatment plans. Members who are not connected to the portal will receive a phone call from their respective caregiver/team member to complete the questionnaire. Clinicians run reports within the EMR to identify their members with depression and the date and score of their

past PHQ-9 results. Decision support reminders within the EMR also facilitate reminders to clinicians to monitor the status of their patients.

C. **Intended Goals and/or Outcomes of the Initiative:** Initiative goals are to provide interventions to members to help them reach remission for their depression or/and reduce depression symptoms as measured by PHQ-9 scores.

D. **Activities Undertaken to Evaluate the Effectiveness of the Initiative:** Monthly performance reports include metrics at the physician, medical office building and medical group practice measuring the use of the PHQ-9 and the reduction and timeliness of PHQ-9 scores.

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 through secure messages and the inclusion of depression screening in a new rooming process, the identification and recruitment of members who qualify for the depression program has improved. Although the impact of the pandemic limited extensive new approaches in 2020, the increase in telemedicine, especially video visits, enabled members to engage in their depression care differently and more actively than when an in-office visit was the expectation. A member will continue receiving contacts as long as their depression is an active diagnosis.

G. **Changes to the intervention strategy:** Per above, the intervention strategy has predominantly changed through the enhancements to depression screening and increase of cases found through a universal screening approach and with the automated referral process based on the PHQ-9 results.

H. **Development of any new initiatives:** The necessity of managing the COVID-19 pandemic in 2020 led to the significant increase in telemedicine, especially for behavioral health and depression management, especially the use of video visits. The program already used video visits for care delivery and the volume increased substantially in 2020 due to the COVID-19 pandemic.

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

Other Initiatives

The program manages initiatives for the other conditions provided for in the Carrier Accountability Report, specifically, asthma management, opioid and other substance abuse disorders, and pregnancy case management. Participation in these initiatives fell below the 300-enrollee reporting threshold.

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 2020 who have participated in the 2020 Diabetes or Depression 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.