Kaiser Permanente Washington Population Health Program Description

March 2020

Contents

Introduction

Kaiser Permanente of Washington (KPWA) has a mission to design, finance, and deliver high quality healthcare and is committed to providing appropriate, comprehensive and coordinated care in collaboration with our members. This means providing the right care in the right place, at the right time, and with the right outcome for our members.

KPWA has developed a population health management strategy to help achieve our quality vision. The KPWA quality vision is aligned with the Triple Aim, a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. The premise of the Triple Aim is to simultaneously pursue three healthcare objectives:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of healthcare.

KPWA's Population Health Program is designed to directly impact the health of our member populations through programmatic design, implementation, evaluation, and continuous improvement. The Population Health Program relies on annual analysis of our member population and segmentation of the population into targeted groups and includes five programs/services that work synergistically to improve the health of our members across the health and wellness spectrum. The programs listed below are not an exhaustive list of all programs and services offered by KPWA, but rather a suite of functions that have been created specifically to work together to impact the health of populations. KPWA's Population Health Program includes the following:

- Clinical Quality Improvement Program
- Complex Case Management Program
- Diabetes Care Program
- Health Profile
- Care Transitions Program

Overall Population Health Program Goals

To achieve our mission of providing high quality, affordable healthcare services and improving the health of our members and the communities that we serve, we must translate that mission into concrete goals. KPWA's Population Health Program includes overall goals and program-specific goals to emphasize the importance of all services working in concert to improve the health of our member population.

2020 Overall Program Goals:

- Readmission rate observed over expected at or below 0.574 for all lines of business
- Achieve HEDIS 90th percentile performance in A1C<8% in the diabetes population
- A1C<8% HEDIS rate of 60% or greater in the Hispanic/Latinx diabetes population

Clinical Quality Improvement Program

KPWA's Clinical Quality Improvement Program works directly with providers to give clinical performance data and expert consultation so that they have the information, tools, and resources needed to provide the highest quality care to our members. The program is two-part and includes consultation to the providers in both the Kaiser Permanente Washington Medical Group (Internal Delivery System) and the contracted network (External Delivery System). While approaches and measurable goals differ between the two, the objective of improving the care of our members through supporting providers is identical.

KPWA Internal Delivery System

KPWA supports the Patient-Centered Medical Home (PCMH) model. The PCMH model develops relationships between primary care providers, their patients, and their patients' families. In the PCMH model, primary care promotes cohesive, coordinated care by integrating the diverse, collaborative services a member may need. This integrative approach allows primary care providers to work with their patients in making healthcare decisions based on the fullest understanding of information in the context of a patient's values and preferences. The medical home team, which may consist of nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, educators, behavioral health therapists, social workers, care coordinators, takes the lead in working with the patient to define their needs, developing a plan of care, and updating a plan of care as needed.

Working alongside the medical home team are the Quality Consultants from the Clinical Improvement & Prevention department. These consultants operate within the PCMH model to improve the quality of care for members and collaborate with the KPWA internal delivery system to support all aspects of clinical quality in both Primary Care and Specialty. Consultations include reviewing quality dashboards, metrics, workflow, and reliability tools, developing and updating various quality tools and "translating" them into clinic workflow, partnering with KPWA's Quality Champions (provider leaders) to support their local Clinical Operations Managers and Medical Center Chiefs, and providing education on clinical best practices to lead specific population-based quality improvement efforts. Quality Consultants also partner with clinical pharmacists to advise on care for individual members as well on population-based strategies.

The Clinical Quality Improvement Program targets many subsets of our member population in the Internal Delivery System. In general, they are divided into Emerging Risk, which includes diabetes, atherosclerotic cardiovascular disease, asthma, depression populations, and Prevention, which includes pediatric immunizations, cancer screening (breast, cervical, colorectal).

Three reports are primarily used during consultation:

1. Cascade Dashboard: HEDIS and Medicare Five Star performance data at the Organizational, Division, Service Area, Regional, clinic and provider levels.
2. RightNow Care Reports: Primary and Specialty care gaps present at a visit and completed 1-2 months later. Reported at the clinic and provider levels for Primary Care. Specialty also reported at service line level.
3. Chronic Disease Management: Reports DM RN Case Management including length of care episode and resulting HbA1c improvement.

Within the Internal Delivery System, the Clinical Quality Improvement Program collaborates with the other functions in the population health program. This includes Quality Consultants meeting routinely with the Diabetes Clinical Nurse Specialists from the Diabetes Care Program to coordinate efforts, priorities and messaging. In addition, the program oversees well care tools and clinical processes and supports the integration of those with Health Profile (the KPWA health risk assessment tool) notifications and other well care related tools. Quality Consultants inform clinical teams of the other population health programs available to member meet needs.

2020 Program Goals:

- Using a cumulative measure of seven HEDIS diabetes indicators, 82.7% of these indicators for internal delivery system members with diabetes will be met
- Using a cumulative measure of five HEDIS cardiac care indicators, 79.6% of these indicators for internal delivery system members cardiac conditions will be met
- Using a cumulative measure of Breast, Colorectal, and Cervical cancer screening HEDIS measures, 78.0% of these screenings will be completed for eligible populations in the internal delivery system

KPWA External Delivery System

KPWA monitors and reports on specific HEDIS and CMS Star measures of prioritized practices in the external delivery system. The measures selected include a range of prevention and emerging risk indicators (e.g. cancer screening, well-child visits, diabetes management, asthma management, medication management, etc.) and were linked to the care of approximately 14,000 Medicare enrollees and 77,000 commercial members seen in our contracted network in 2019.

In parallel to providing monthly updates on clinical performance using these measures, KPWA distributes monthly reports that inform external delivery system provider groups about members who currently have gaps in care. The clinics use these lists to engage patients and provide supplemental evidence or exclusion information back to KPWA through KPWA's medical record FaxBack program. Additionally, KPWA sends a team of medical record review specialists to assess the records of 15,000 Medicare enrollees to identify missed evidence of treatment or exclusions from the measure denominators. In 2018, KPWA implemented the distribution of a new active enrollment report to the clinics to further enable them in proactively engaging patients.

Several programs are in place to enhance performance on prevention and screening in the contracted network. These include a mammography partnership, where outreach lists are provided directly to key partners, a FIT kit mailing program for members who are due or coming due, and a post-fracture outreach program to identify members for osteoporosis screening.

KPWA supports practices' efforts to implement proactive outreach and opportunistic care strategies and has designed two programs (Quality Incentive Program and Medicare Stars Program) to incentivize external delivery system providers to close gaps in care. The first program is focused on the Commercial population and encourages clinics to achieve 50th, 75th, and 90th percentile on 17 HEDIS measures. The second program is focused on improving health in the Medicare population and provides a financial incentive to the clinics based on achieving a four- or five-star performance on 15 CMS Part C and Part C measures. KPWA regularly monitors the performance of incentive program participants and, on a semi-annual basis, sends a multi-disciplinary team to consult with the senior leaders in those organizations. The KPWA faction consists of a health plan medical director and experts from quality, pharmacy and provider relations. During these meetings, KPWA reviews quality measure performance trends, offers insight on best practice strategies, shares new regulatory definitions and expectations, and discusses barriers that practices may be experiencing at the health plan level.

The external delivery system portion of the Clinical Quality Improvement Program collaborates with other services provided in the Population Health Program by providing education to contracted network providers about the Complex Case Management Program, Care Transitions Program, and Health Profile. These services are all available to members and can provide additional resources and support to the external delivery system providers. Furthermore, KPWA manages the quality improvement initiatives through a centralized population health team that includes patient safety, continuing medical education, and screening and outreach. Initiatives that are generated by that department are conveyed to the external delivery system through regular quality improvement consultation.

2020 Program Goal:

- Improve the external delivery system quality composite rating, which is a sum of all the measures[1] by 1.0% between January and December each year for KPWA members receiving care from external delivery partners who participate in the annual incentive and Medicare stars programs.

Health Profile

The Health Profile is an interactive health risk assessment on the KPWA secure member site that collects clinically useful information (e.g. current and past medical history). It produces an online personal health report for each member with customized recommendations for medical screening,

[1] HEDIS: Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, Child and Adolescent Well Care, Child and Adolescent Immunizations, Diabetic Testing, Diabetic Nephropathy, Diabetic Retinal Exam, Diabetic Statin Use, ASCVD Statin Use, Asthma Medication Ratio, Asthma Rx Compliance, Anti-depressant compliance 84 and 180 days

chronic disease management, and health promotion. In addition, the Health Profile integrates the report into Epic. For members getting care in the internal delivery system, the Health Profile generates an electronic alert to the member's care team or Care Management if the member has poor control of a chronic condition or trouble managing medications.

The Health Profile is designed with complex branching and content may differ based on responses to a given question. Reporting categories also differ depending on responses. For example, a member who indicates they have diabetes will be asked further questions about their diabetic care and have a section in their report addressing those responses. This allows the member to input and view only the information that is relevant to them.

The current Health Profile is available to all members over age 18 who have an ID-verified account on the KPWA secure member site. It is available 24/7 and members can complete Health Profiles as often as they like. ID-verified members can start a Health Profile by clicking a link on the home page and agreeing to a disclosure or they can opt out at that point by canceling the agreement. When the member accesses the interactive tool through the secure member site, they are provided with instructions on how to use the Health Profile. If a member does not have access to the secure member site, they can call to request a paper copy of the Health Profile. Many members are incentivized by their employer to complete a Health Profile and the Health Profile is also promoted on KPWA's public-facing website and secure member site as well as in print flyers that are distributed in outreach letters and via secure message when a member schedules a well visit with a KPWA provider.

The Health Profile works in collaboration with all the other population health management programs in that the results are available in the member's electronic medical record for any of the clinical staff of the other programs to review and utilize. Moreover, members identified with complex needs through Health Profile can be referred directly to the Complex Case Management Program or Diabetes Care Program.

2020 Program Goals:

- At least 30% of adult well visits have a Health Profile completed in the 6 months prior to the visit
- At least 70% of Health Profiles completed within 30 minutes

Complex Case Management Program

KPWA's Complex Case Management (CCM) Program is designed to serve the most vulnerable members. Our CCM Program plays a vital role in supporting members with the navigation of medically, emotionally, and socially challenging situations that prevent them from achieving their health goals.

The current program includes a total of eight full time RNs and two full time LPNs. These clinical team members work together to carry a panel of members who have been identified with complex needs. Members are identified as eligible for CCM in two ways: 1) The John Hopkins ACG score is a tool used to identify members with complex needs who need further assessment for CCM service, 2) The KPWA Likelihood of Readmission Risk Stratification Tool is used to identify members at risk for readmission following hospital discharge and refer those who may benefit from CCM.

All providers are informed of the CCM Program and criteria through the KPWA intranet, patient portal, or provider website and can refer members directly. Internal KPWA providers can place a referral through our electronic medical record, Health Connect, or by calling a toll-free number. Information on the CCM Program is provided on the member website and through brochures and any members can self-refer to the CCM Program. Members are informed of their eligibility for the program via phone call from a Complex Case Management nurse. At the time of the initial call with the member, the CCM nurse also explains how to utilize the services in the program and how to opt in and out of the program.

Members with chronic conditions and those with complex needs are also eligible for CCM services. The CCM Program especially targets members with asthma, COPD and heart failure due to the complexity of management of these conditions and the risk for hospitalization. Referring providers are asked to assess if the member meets more than one of the following characteristics in addition to a chronic condition or significant acute illness:

- Lack of an established care plan
- Evidence of high or frequent utilization of healthcare services
- Evidence of seeing multiple providers
- Seeing external providers
- Overdue labs/medications not filled timely
- Compromised safety/frail elderly with problems
- Lack of support system
- Financial problems (can’t afford medications, copays, etc.)
- Patient safety (frequent falls, medication adherence, etc.)

At the time of the first call, the member gives verbal consent to work with the nurse and to have their PCP or specialist informed of any ongoing issues or work that the member does within the CCM Program. The RN also works with multiple departments such as lab, radiology and other clinical areas depending on the needs of the member. Following enrollment, the nurse conducts a comprehensive assessment that evaluates the members physical health, behavioral health, environmental concerns, psychosocial needs, safety, medications and activities of daily living. The CCM nurse then works collaboratively with the member to develop goals that are meaningful and to translate those goals into concrete steps for the member to work on with the support of the CCM nurse. The collaboratively developed self-management care plan is then sent to the member, PCP, and other members of the care team. Members are typically enrolled in the program for a minimum of 60 days and average between 60 and 120 days. The CCM nurses reassess members for continued use of the services at 90 days and then every 30 days thereafter.

The Transitions Management Program is part of the CCM program, so these programs collaborate closely. These programs are staffed with the nurses described above in the Care Management department. The team works to identify if members would be better served by the shorter-term, transitions-focused services of the Transitions Management Program or CCM Program. Similarly, the CCM Program nurses collaborate with the staff in the Diabetes Care Program in case the member may be served better by a more condition-specific program. When consultants from our Clinical Quality Improvement Program consult with our provider clinics and groups, they work to promote the services available to members through the CCM Program.

2020 Program Goals:

- 55% of members engaged in Complex Case Management will meet their stated health goals
- 90% of members surveyed who engaged in the Complex Case Management will report they were satisfied with the care they received in the in the program

Diabetes Care Program

The Diabetes Care Program was designed to support quality care for the diabetes population at KPWA. The role of the team members is to provide support to primary care in the form of education, training, and clinical consultation for nursing and medical staff across the care delivery system. A key factor of that support is the population care nursing staff who are centrally managed by the Diabetes Care Program, but locally deployed in primary care, as well as the team RN staff in primary care. The population care nurses and team nurses create individual member care plans through a process called chronic disease management (CDM) which include the following principles: RN assessment, facilitation of treat to target goals for diabetes, hypertension, and other chronic care needs for patients with diabetes in collaboration with the primary care provider (PCP). The care plans emphasize self-management, focused interventions to work towards goals, and treating the whole person (e.g. diabetes, blood pressure, depression, etc.).

Ideal candidates for enrollment in the Diabetes Care Program are members of the diabetes population who have symptoms and concerns, multiple comorbid conditions, or a HbA1c and/or blood pressure above target. However, all KPWA members in the internal delivery system who have diabetes with a HbA1c over 8% or require focused interventions to work towards goals, regardless of HbA1c, are eligible for CDM. There are two ways members can be informed of eligibility for chronic disease management:

1. A provider can identify a member with diabetes that could benefit from CDM (regardless of HbA1c level) and send a referral to the RN. The patient will be informed of this referral by the provider in an in-person visit, secure message, or phone visit.
2. A RN may proactively outreach to any patient with a HbA1c over 8%. The RN will invite the patient to participate in chronic disease management by secure message or phone.

In either scenario, the member can discontinue participation in the program at any time by informing the nurse. During the first visit with the member, the nurse will inform the member of how to utilize the program services. Program services are primarily accessed via secure message or phone visits, with in-person visits as an additional option.

All members enrolled in chronic disease management are monitored within Health Connect via a report called the CDM Tracker. From this report, the success of chronic disease management can be measured by identifying if in-process and outcome measures are met. The candidate list, a report with all the members at KPWA not already enrolled in chronic disease management with a HbA1c over 8%, is also used to identify members of our target population.

The nursing staff who perform chronic disease management often coordinate care with Complex Case Management nurses for patients with multiple comorbid conditions. The Diabetes Care Program also relies on the Health Profile, reminder calls, and care gap outreach to inform members of our diabetes population when to receive labs, screenings, etc.

2020 Program Goals:

- Reduce the average HbA1c by 1.5% over 6-12 months for all members enrolled in chronic disease management.
- 90% of members surveyed who engaged in the Diabetes Care Program will report they were satisfied with the care they received in the program

Care Transitions Program

The Care Transitions Program acts as a bridge and provides support services to ensure members' safe passage during particularly vulnerable transitions. As an integrated health plan and delivery system, KPWA ensures safe transitions for members in a variety of ways.

In our internal delivery system, we have a variety of tools and reports that track when a member enters the urgent care, emergency room, and/or hospital. The member's PCP is notified about the encounter and the primary care team supports the coordination of the members care. KPWA has nurses, physicians, and social workers in seven of our rounded hospitals that oversee the care of our members and ensure they have a plan in place to safely transition to the next appropriate setting. KPWA members that are hospitalized in non-rounded hospitals receive oversight and management of their hospital stay and plan for discharge from a centralized group of nurses that work telephonically with the hospital treatment team.

When a member discharges from the hospital, they receive a post-discharge phone call from a nurse who reviews the four pillars: medication knowledge, review of care plan, follow up appointment, and knowledge of red flags/when to reach out for help. These calls serve as an identification point for members who would benefit from Transition Management, Complex Case Management, or the Diabetes Care Program— services to ensure that the member receives the care they need as they transition back to their daily routine and providers. Members who meet the criteria below are offered medication reconciliation in addition to a post discharge phone call through the Care Transitions Program services.

- Members at increased risk for hospital readmission receive a more comprehensive medication reconciliation in advance of their follow up appointment.
- Members who get their care in the KPWA internal delivery system get medication reconciliation with a clinical pharmacist who reviews their medication and ensures there are no contraindicated medications, that the PCP is aware of any critical medications that may have been discontinued, that the patient is taking the appropriate medications.
- Members who get their care in the external delivery system get medication reconciliation from a RN who does a comparable review but coordinates with the external providers and PCP to address any identified discrepancies.

The Transition Management (TM) Program is a service offered within the Care Transitions Program to any KPWA members who need assistance with coordination of care for a short-term period. These members may have difficulty navigating the health system due to frailty, illness, lack of social supports or other psychosocial issues. Some examples of the care and support nurses provide include getting a member connected with specialty care (e.g. oncology or orthopedics) or to a primary care provider as needed. TM case managers could help members get referred to other care programs and services offered by KPWA that could address their ongoing care needs. The nurses offer support and education to members about their illness and/or medications.

There are currently eight full time nurses that work with members providing TM services. Members are notified of their eligibility for TM services by a phone call from the nurse. At the time of the initial call, the TM nurse will inform the member of how to utilize the services in the program and how to opt in and out of the program. Members that are enrolled in TM typically are enrolled for 30 to 60 days. If their needs require longer management, they may transition to CCM once their care transition needs are met. Referrals for TM services may come from hospital staff/teams, consulting nurse services, customer service, PCP or other care team members, or self-referral of the member directly to the care management department. Members can see Care Management services offered from the KPWA website and providers can place referrals via the intranet or our internal website or by calling a toll-free number.

2020 Program Goals:

- 80% of all Medicare and/or orange pathway (high risk) members with an inpatient hospital stay will receive a post-discharge phone call within seven days of being discharged from the hospital.
- 90% of Medicare members with an inpatient hospital stay will have a completed medication reconciliation within 30 days of being discharged from the hospital.

Informing Members about Population Health Services

KPWA uses the Quality page on the member website to inform members about our Population Health Program. This webpage provides a brief overview that helps members understand our approach to population health and services, as well as links to additional information. Additionally, a link to the Population Health Program Description is included to provide members with more details.

Members are informed about their eligibility for programs and services within the Population Health Program in a variety of methods, including website, secure messaging, phone calls, and letters. More details regarding informing members of their eligibility are included in the descriptions of individual programs.

Providing Support to Practitioners

KPWA views all the providers who provide care as crucial partners to ensuring that our members receive safe, high quality, and evidenced-based care. KPWA has developed a variety of programs and services to ensure that providers have the data, tools, knowledge and incentives to provide the best care for our members.

As mentioned above, KPWA's Clinical Quality Improvement Program shares comprehensive reports of health system, clinic, and member specific data with providers. To complement the quality performance data, KPWA also provides expert consultation to share tools, resources, and best practices to improve performance and support heathy outcomes for members. KPWA has three value-based payment programs in which providers are given a financial incentive if they achieve high clinical quality outcomes. These programs are designed to work in tandem with the data and consultation providers receive to provide additional incentives for good patient outcomes: The Annual Incentive Plan for WPMG and Quality Incentive Program and/or Medicare Stars Program for external providers in the contracted network. These three programs ensure that many of our members see a primary care provider who participates in at least one of these value-based programs.

In addition, KPWA is committed to providing resources and support to give providers access to the most up to date clinical knowledge. The Office of Continuing Medical Education regularly develops CME programs and products that provide health care practitioners with evidence-based knowledge and tools to promote effective patient care decisions and efficient practices. KPWA offers the full spectrum of CME activities for providers including full day CME conferences, performance improvement CME (PI-CME), Advanced Life Support Certification training (ACLS, NRP, PALS), case conferences, videoconferences, online CME, consultative specialty CME outreach and WSMA accreditation application facilitation. In addition, KPWA provides access to video and web-based shared decision-making aids to support collaborative conversations between providers and patients utilizing the most up to date evidenced-based knowledge.

Annual Assessment of Population Health Program

Overall Program Assessment

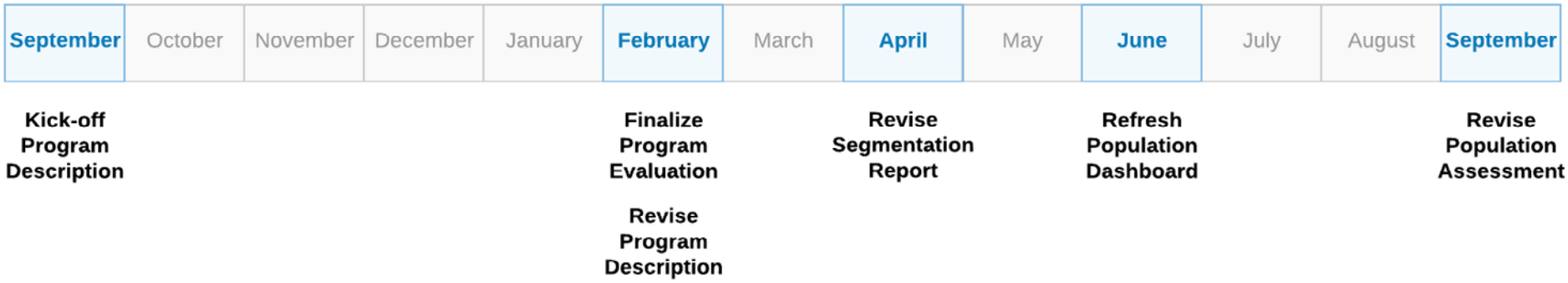
KPWA's Population Health Program must be assessed rigorously and regularly. The first step to developing a meaningful evaluation is setting program goals and objectives. On an annual basis, the Population Health Program description is revised and KPWA will review overall and individual program goals based on the previous year's performance. Qualitative and quantitative analysis on relevant clinical, utilization, and experience measures, is conducted to evaluate the efficacy of the program. These results are interpreted and used to develop the coming year's targets. During this period of evaluation, KPWA will consider the revisions, additions, or elimination of programmatic services to better meet the member population's health needs.

Population Assessment

In addition to the evaluation of the Population Health Program, KPWA also assesses the needs of our member population. The population assessment is conducted annually in Q3-Q4 and uses the previous year's member data to assess the health and needs of members. At minimum, the annual population assessment examines the characteristics and needs, including social determinates of health, of our member population. The population assessment identifies and assesses the needs of relevant subpopulations, children and adolescent members, members with disabilities, and members with serious and persistent mental illness. This information is then used to make recommendations regarding the population health management program as well as other services and functions that could better meet the needs of our member population. KPWA uses the population health assessment to identify potential gaps in care and services that do not have a current population-based strategy and recommend areas of opportunity for KPWA to serve our particularly vulnerable members. Figure 1, below, outlines the annual process for the ongoing evaluation of our Population Health Management Program.

KPWA Population Health Management – Evaluation Timeline

Figure 1



Population Segmentation

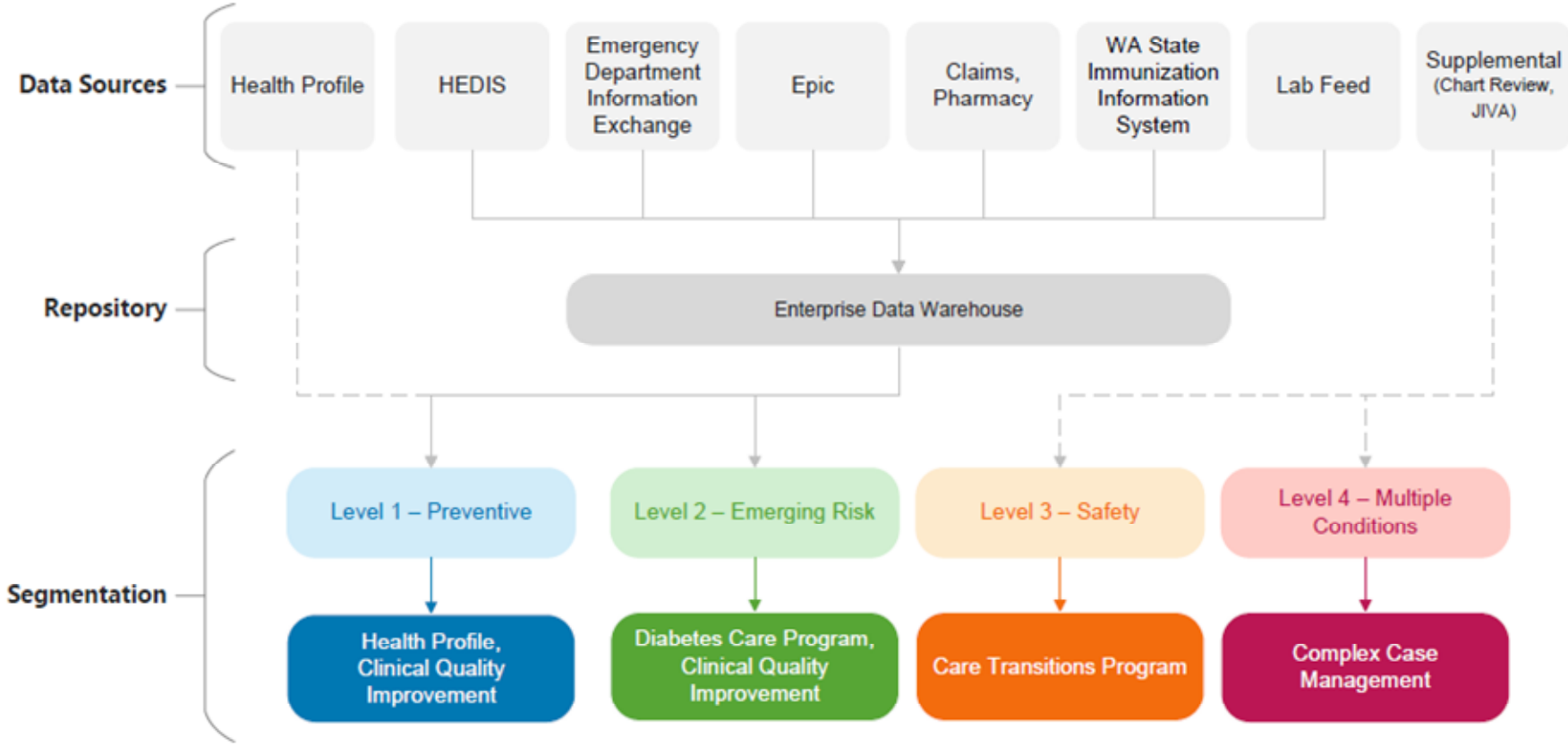
KPWA receives data of our members' health and healthcare utilization from a variety of sources. We use this data to further segment our population and ensure that we have programs in our Population Health Program that address the needs of the smaller segments of the population. Figure 2, below, is a conceptual model of KPWA's approach to the segmentation of our member population. Annually, KPWA completes a segmentation report and this report allows us to segment the entire member population into four intervention levels.

- Level 1: Preventive Care Needs
- Level 2: Emerging Health Risks
- Level 3: Health Safety Concerns
- Level 4: Multiple Chronic Conditions

Within each intervention level, the report further segments the population by the programs and services (e.g. Complex Case Management) designed to address member care needs. KPWA uses the previous year's data from claims, electronic medical records, health risk assessments, laboratory data, immunization records from the Washington state database, case management documentation systems, and EDIE (Emergency Department Information Exchange) to identify which populations belong to each level of intervention. This information is stored within various systems and the segmentation report pulls data directly from those sources or from the KPWA Electronic Data Warehouse (EDW). The segmentation report then stratifies the subpopulations within each level and helps determine which Population Health Programs are targeted to meet those needs of the populations at each level. The segmentation report is completed in conjunction with the population health assessment on a yearly basis.

KPWA Population Identification – Segmentation Overview

Figure 2



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Summary

KPWA's Population Health Program is built on decades of experience of integrating population-based strategies into the health systems that serve KPWA members. The programs and services within the Population Health Program are designed to improve the health and wellbeing of members. KPWA is committed to ongoing rigorous evaluation of our program and will continue to look for ways to improve the program and revise services when needed.