In the United States, direct medical costs for chronic conditions are expected to reach $1.07 trillion by 2020. Chronic conditions such as diabetes, asthma, and heart disease account for the biggest portion of health care costs. Chronic conditions can reduce employee productivity by causing absences from work and preventing employees who are present at work from performing at their best.

At Kaiser Permanente, we excel at providing cost-effective, quality-focused disease management. Helping members stay healthy and productive is our first priority, and disease management enables us to combine preventive care, specialty care, self-management, and health education so that members with chronic conditions can enjoy a better quality of life.

**Complete Care: Quality-Focused Disease Management**

Disease management has always been built into the way we deliver care. We believe preventive care and a healthy lifestyle can make a big difference in everyone’s life; that’s why it’s a part of our disease management programs for those with chronic conditions. Members get care for their total health at every stage of life. It’s what makes our Complete Care approach different—and what makes it work so well.

We have care management programs for various chronic conditions including asthma, diabetes, coronary artery disease, depression, HIV/AIDS, and heart failure, among others. Offerings may vary among the regions.

Our Complete Care programs:

- Regularly screen members for chronic condition risk factors
- Offer preventive services to members at all levels of health
- Require no “opt-in” or referral—members with chronic conditions are automatically included as part of their plan enrollment
- Are customized for each patient’s individual needs
- Provide proactive, targeted clinical interventions
- Use a multidisciplinary health care team approach
- Offer physicians automated clinical decision-support and practice tools
- Provide health information technology support (electronic medical records, clinical decision support, online member health services)
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- Empower members with self-care education
- Track member progress in managing chronic conditions
- Measure defined outcomes to ensure program value

What distinguishes our care management programs?

- We intervene with patients early, even before they have symptoms or have been diagnosed with a disease, using patient health status, risk factors, and family history to assess their risk status for a chronic condition. This means conditions are well controlled or prevented before they reach an advanced stage that requires greater usage of more services.

- We don’t use dollar triggers to initiate case management. We use the more direct and effective method of automatically enrolling members in disease management registries based on health status and patient information, rather than the anecdotal information provided by merely using dollar figure triggers.

- Our program is seamlessly integrated into our patient-centered, “whole person” continuum of care—it’s not a separate carve-out program through a vendor that costs our customers extra money. Because we coordinate and provide every aspect of care, our integrated approach helps to ensure continuity of care and simplifies consultation among caregivers, who have direct access to members’ health information.

- Simplified coordination among providers through an integrated system that combines health plans, medical care, laboratory and imaging services, pharmacies, and hospitals from one interconnected organization. All providers can securely access Kaiser Permanente HealthConnect®, our electronic medical record, and view test results and other physician notations, which helps reduce duplication of lab tests, unnecessary medical visits, redundant utilization of services, and pharmacy errors.

Beyond this, we also have several features that differentiate us from other health plans. We empower members for self-management. When patients understand their conditions and are engaged in self-management, their health outcomes usually improve. But member self-management doesn’t mean that members are on their own. Although members are encouraged to take an active role in understanding and managing their conditions, they do so with the support of a multidisciplinary team of caregivers.
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How Care Management Works

Kaiser Permanente members with specific medical conditions are automatically identified using disease-specific case identification protocols through various types of clinical and administrative information from pharmacy, laboratory, outpatient encounters, and hospital discharge data systems.

Candidates for care management programs are risk-stratified into two general categories: low-to moderate-risk and high-risk. Risk-stratification enables us to provide members with appropriate, customized care so that we can optimize positive health factors and prevent the development of disease. Specific programs for the low to moderate level of risk may vary by region.

Low to Moderate: Low- to moderate-risk members are those with a chronic medical condition that is relatively well controlled with no severe complications. Some patients may present mild complications or comorbidities that are managed through self-care and education. Low- to moderate-risk members are cared for by their personal practitioners and provided with specialty care when appropriate. They may also receive ongoing condition-specific educational programs, preventive services, and monitoring. These programs are interventions designed to empower members to learn self-care skills and make lifestyle changes to effectively manage their condition.

High: High-risk members are patients whose medical problems are complex and require aggressive, high-intensity care management. This group can include patients with recent hospitalizations or Emergency Department visits, and those requiring intensive management across multiple departments due to co-morbidities or complex medical or psychosocial issues. High-risk members are closely monitored individually by a clinical case manager and a specialist, who act as their primary care physician, who oversee their care.

How does Kaiser Permanente identify the diseases for which programs are developed?

We have identified several chronic conditions that would impact our population and for which coordinated care management approaches are proven or likely to improve quality and effectiveness. Kaiser Permanente’s care management programs are sponsored by regional ambulatory care steering committees composed of Permanente physicians and other
administrators. These committees identify specific population groups of both moderately and severely affected patients whose health can be improved by clinically proven interventions.

Additional factors influencing program development are resource utilization patterns, such as noticing a high volume of Emergency Department visits or pharmacy usage among a specific disease population, and the clinical recommendations of our own Permanente physicians.

Outreach Programs for Disease Management

Our approach to disease management consists of identifying patients at high risk for chronic conditions and proactively intervening to treat the conditions effectively while also promoting patient self-management. The goal of disease management is to help patients better manage their chronic illness, improve their health status, and increase their quality of life. We reach out to them in several ways, including:

Outreach
We have a proactive approach to preventive screenings using a variety of member reminder methods, including mailings and telephone reminders that use interactive voice recognition (IVR).

In-reach
Through KP HealthConnect, physicians receive reminders/alert prompts when a member, who may be overdue for a mammogram or colon cancer screening, presents for an office visit. These same reminders are available to members through kp.org. If a screening result is positive, we have dedicated resources to track members who require follow-up.

Methods of Delivery

Multiple methods of delivery are used for the above interventions, including:

- targeted and general mailings for annual flu shots for seniors and other high-risk members, breast and cervical cancer screening (mammograms and Pap tests), child and adult immunizations, cholesterol testing, diabetes testing
- kp.org (My Health Manager)
- live outreach calls telephone
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- automated telephone reminders, automated voice services (AVS), or interactive voice recognition (IVR)
- face-to-face appointments or sessions
- health information technology (KP HealthConnect)
- A quarterly newsletter, available in most regions, provides educational information on smoking cessation classes, weight management programs, and other preventive care services available to our members

Provide an overview of your case management program.

Case management is focused, high-level care for members with significant medical problems. It allows for the coordination of resources among providers, facilities, services, and treatment options to meet the specific needs of the high-risk member.

Case management involves a systematic process consisting of:
- Identifying high-risk members
- Offering comprehensive assessment of their needs
- Providing assistance in setting realistic treatment goals
- Coordinating care provided by a team of physicians and other health care professionals

Our case managers are physicians, registered nurses, social workers, respiratory therapists, and pharmacists who work directly with members and their health care teams to plan care and provide intensive coordination of services. Case managers coordinate inpatient hospitalizations, transitional care, home care, skilled nursing, medications, referrals to community resources, and outpatient care.

Case managers help to ensure continuity of care, including utilization management, transfer coordination, discharge planning, and obtaining all necessary authorizations or approvals for outside services for members and their families. Case managers are also responsible for identifying quality-of-care problems and monitoring utilization issues. They work with members, families, clinicians, and community resources to coordinate care delivered within Kaiser Permanente facilities and through outside contracted providers.

Members in need of case management are identified through clinical and utilization data from our disease registries, pharmacy records, hospital and outpatient visits, and laboratory results.
Members can be referred to case management by a physician or family member, or they can self-refer if they feel they have the need and meet the requirements.

In addition to and separate from our hospital care teams, our Complex Case Managers are RNs with an extensive medical/surgical clinical background, typically located in our medical offices. They are patient advocates and educators, assisting the physician and empowering the member and the family in making optimal health care decisions to help ensure high-quality, cost-effective outcomes. Our integrated population health management approach incorporates the methods and functionalities of utilization management, case management, disease management, and wellness programs as well as medical, economic, and psychosocial expertise to address the needs of the whole person. This approach allows members with high-risk, chronic, or complex conditions to move easily through appropriate levels of care, minimizing member frustration.

The goals of our case management program include:

- Improving outcomes
- Increasing member satisfaction
- Improving cost effectiveness
- Reducing the frequency of repeated admissions or Emergency Department visits
- Improving clinical appropriateness
- Improving continuity of care by streamlining transitions between multiple providers and levels of care
- Maximizing the effective use of limited health plan benefits

In keeping with our philosophy of “Complete Care,” we provide comprehensive case management that considers a member’s physical, psychological, and emotional state, as well as cultural needs. Through this Complete Care approach, we avoid unnecessary interruptions or delays in services for members with complicated care needs, catastrophic illnesses or injuries, and ongoing physical and behavioral health conditions. Any time a potentially catastrophic case is identified, the member is immediately referred to the appropriate case manager.

Candidates for case management vary from region to region, but typically include members with high-risk pregnancies, asthma, diabetes, congestive heart failure, cystic fibrosis, HIV/AIDS, end-stage renal disease, organ transplants, complications from chronic conditions, as well as the frail elderly and the terminally ill.
Connecting the dots—Integration Is the Difference

Kaiser Permanente HealthConnect® brings together all aspects of care by linking every member, caregiver, hospital, medical office, pharmacy, and laboratory in our system. Physicians have immediate access to the latest medical information and can quickly communicate with their colleagues. With quick access to vital information, they can work more efficiently and focus on care delivery.

By having this information integrated into one secure electronic record, KP HealthConnect enhances the way physicians work together.

- **Improves clinical outcomes** because physicians have complete knowledge regarding comorbidities, past visits and issues, and recommendations from other clinicians so they’re not making care decisions in a vacuum.
- **Supports proactive patient care** through system alerts that catch abnormal results, negative trends, and potential drug interactions.
- **Improves management of chronic conditions** by providing recommended treatment guidelines, decision support, and best practices.
- **Enables the provision of multiple services in a single visit**, reducing the need for additional appointments.
- **Reduces duplicate and unnecessary tests and procedures** because clinicians have access to complete, up-to-date member information.
- **Reduces redundant entries and improves efficiencies** because physicians can prescribe medication, order tests, and provide referrals from a single system at the point of service.
- **Enhances clinical research** because patient data is available in unprecedented quantities, allowing for more complete research and reporting.

Our integrated system of care enables the rapid, thorough dissemination of effective new ideas and practices. According to the Institute of Medicine, it typically takes five to 17 years before a new best-care practice becomes the standard for even 50 percent of specialists in a given area. However, in Kaiser Permanente’s integrated delivery system, we can go from cutting-edge knowledge to implementation in just one year. This is key when it comes to implementing effective care practices that are cost-effective.
How does Kaiser Permanente measure the success of the care management programs?

With Kaiser Permanente's integrated health plan model, shared information and communication systems offer a distinct advantage for measuring clinical performance. The same data that allows us to identify care management patients also enables us to track clinical outcomes and care improvements for individuals and entire care-management population groups. Our physicians and care managers receive comprehensive and timely patient information from risk assessments, office visits, hospital admissions, pharmacy prescriptions, lab tests, and other sources. Our disease registries and databases enable physicians to closely monitor the progress of patients with special needs and deliver the appropriate level of services.

We primarily measure the success of our care management programs through reports on clinical outcomes and member satisfaction. Kaiser Permanente participates in a number of external reports on quality of care, including the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS®)*. HEDIS reports evaluate the effectiveness of care for several clinical measures, including asthma and diabetes management.

We also report on a number of internal clinical measures using regional tracking systems that capture patient data on pharmacy, lab, and office visits.

Because we have been conducting internal reporting for quite some time, we can also capture long-term (up to five to six years) performance trends in most clinical areas; this is a major strength of our integrated health plan. When we find area-to-area variation, we can analyze and validate the better outcomes and then coordinate the sharing of best practices among clinicians in all of our service areas.

**Positive Outcomes**

Some of the positive outcomes we’ve achieved through our disease management programs include:

- **Lower asthma hospitalization rates**
  The National Hospital Discharge Survey (NHDS) found that the national rate for hospital
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admissions for adults and children was 12.5 per 10,000, compared to our rate of 5.4 per 10,000 continuously enrolled members. Compared to other health plans, our score for use of appropriate asthma medications is at or above the national 90th percentile in Northern California, Colorado, Georgia, the Mid-Atlantic States, and the Northwest.

**Better control of blood sugar among members with diabetes**
Control of blood sugar among members with diabetes has steadily increased since 1996, resulting in a lowered risk for diabetes-related complications.

**Excellent care for commercial members and seniors**
We strive to provide members with a tailored health plan that delivers quality care. One measurement of our efforts is the results of the National Committee for Quality Assurance (NCQA) survey. One of the nation’s foremost assessments on health care performance, NCQA gave all of our eight regions the highest rating of “Excellent” in the Commercial HMO and Medicare-contracted product lines.

**Outperforming national averages for care**
Our care-management programs for beta-blocker treatment following a heart attack and diabetes rate in the top 10 percent of all Medicare plans nationally, according to HEDIS scores.

**Top-ranking care**

Kaiser Permanente has the top-ranked health plans in the nation in both Medicaid and Medicare, according to a joint ranking by *U.S. News & World Report* and the National Committee for Quality Assurance. The December 2009 issue, “America's Best Health Insurance Plans 2009 – 10,” ranked the nation's top commercial, Medicare, and Medicaid health plans based on clinical quality data, member satisfaction and NCQA accreditation scores.

Kaiser Permanente Colorado is the No.1 ranked Medicare health plan in the country, while Kaiser Permanente Hawaii took the top spot in the Medicaid rankings.

**A-L-L Initiative for Heart Disease and Diabetes**
Research from the Kaiser Permanente Care Management Institute (CMI) showed that the combined use of relatively low daily doses of two generic drugs—lovastatin and lisinopril—can reduce the risk of heart attack or stroke by more than 60 percent in individuals with heart
disease or diabetes. The results of the CMI study were formally announced in the October 1, 2009, issue of *American Journal of Managed Care*. Over a period of three years, the number of members taking both ACE inhibitors (lisinopril) and cholesterol controllers (lovastatin) increased 44 percent across our program.

**Recognized for Cost Efficiency**

In all of our regions, the Kaiser Permanente plan is ranked #1 for financial efficiency across all product and funding offerings, according to the Hewitt Health Value Initiative™ report.**

Also, Hewitt and Associates rated Kaiser Permanente with the highest clinical quality in every region.

* HEDIS (Health Plan Employer Data and Information Set) is a registered trademark of the National committee for Quality Assurance.

**Customers can obtain the full Hewitt Health Value Initiative report by contacting their sales representative or account manager.