

# Population Health Management:

How WE Can Make a  
Difference

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# Disclosures

- **Medical Director, Blue KC**
- **Family Physician**
  - **Private Practice**
  - **Academics**
  - **Administration**

# Overview of Blue KC

1

Of 34 Blue plans



1

Million members



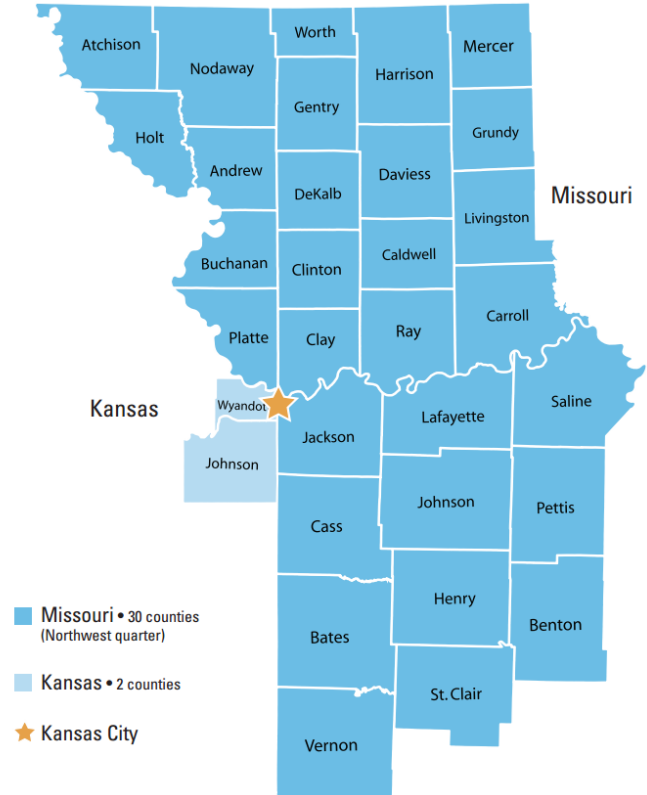
1K

Employees at Blue KC



\$1.8

Million in community giving in 2016



**32 county service area**  
 30 counties in Northwest Missouri  
 2 counties in Kansas

# What does “Population Health” mean to you?

Combination of  
public health  
and healthcare

Individual outcomes  
vs. outcomes as part  
of a distinct group

Patient panels, diagnoses,  
demographics, socio-  
economic, family unit,  
communities

## Population Health

Social and  
physical  
implications

What other factors have  
impact on wellness?  
Disparities in healthcare

Movement from episodic,  
acute care to longitudinal,  
focused relationships with  
measurable outcomes

# Population Health Management



The outcome of healthier people, produced when there's aligned payment and benefit structures, and actionable information leveraged by engaged care teams to facilitate physician and health system accountability in the effective management of a population.

# Guiding Principles



## WE ACT

as a trusted partner and guide in identifying innovative solutions that deliver value to all of our customers – members, employers and providers.



## WE EMPOWER

providers and patients to achieve the patient's best health at the lowest cost



## WE ALIGN

products and benefit designs with provider payment strategies.



## WE ACT

as change agents in the community as necessary to drive value for our customers and across our community.

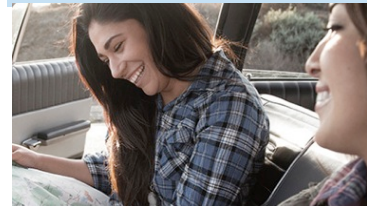


## WE ENCOURAGE,

recognize and reward strong primary care with our providers, members and employers.

## WE ANALYZE

and understand healthcare data to identify improvement opportunities across providers, members and employers.



## WE REWARD

patient engagement and individual health improvement efforts of our members.

## WE DEMONSTRATE

value to our employers.



## WE ADVOCATE

for and incentivize integrated care across the delivery system regardless of ownership.



## WE BALANCE

innovation with fiduciary responsibility

# Driving Transformative Change



Blue Ribbon Panel



Blue KC's Medical Home Advanced Primary Care Programs



Comprehensive Primary Care Plus (CPC+)



Healthier People, Higher Quality, Smarter Spending

## Results at a Glance



# \$12.31

Medical Home patients cost \$12.31 PMPM less on average than non-Medical Home patients.\*



# \$2.00

An increase of \$2 PMPM in savings over 2015 performance.

\*Risk adjusted

9% less  
Inpatient  
Use

12% less  
Outpatient  
Use

23% less ED  
use

Higher  
Cancer  
Screening  
and Diabetes  
Compliance

As compared to non-Medical Home performance



*Today's health plan members are not the members we've covered in the past. They require more care management than ever.*

# Assumptions: Necessary Data Elements



## Prevention

- Predictive value of “heading off” chronic disease
- Identify those at risk
- Encourage evaluation



## Identification

- Evidence based, cost effective treatment
- Metrics, outcomes



## Coordination of care



## Education

# Population Health Initiatives to Improve Patient Care



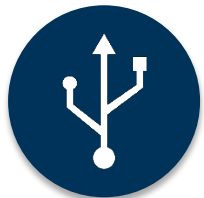
## Evaluate the high cost of care

- Unnecessary, inefficient testing (labs, procedures, prescriptions) that do not lead to improvements in outcomes



## Examine data to identify areas of intervention

- Different physician provider groups
  - High performing efficient vs low performing inefficient



## Choosing Wisely, CDC guidelines, USPSTF



## Educational opportunities

# Staff Need: Different and Enhanced Skill Sets

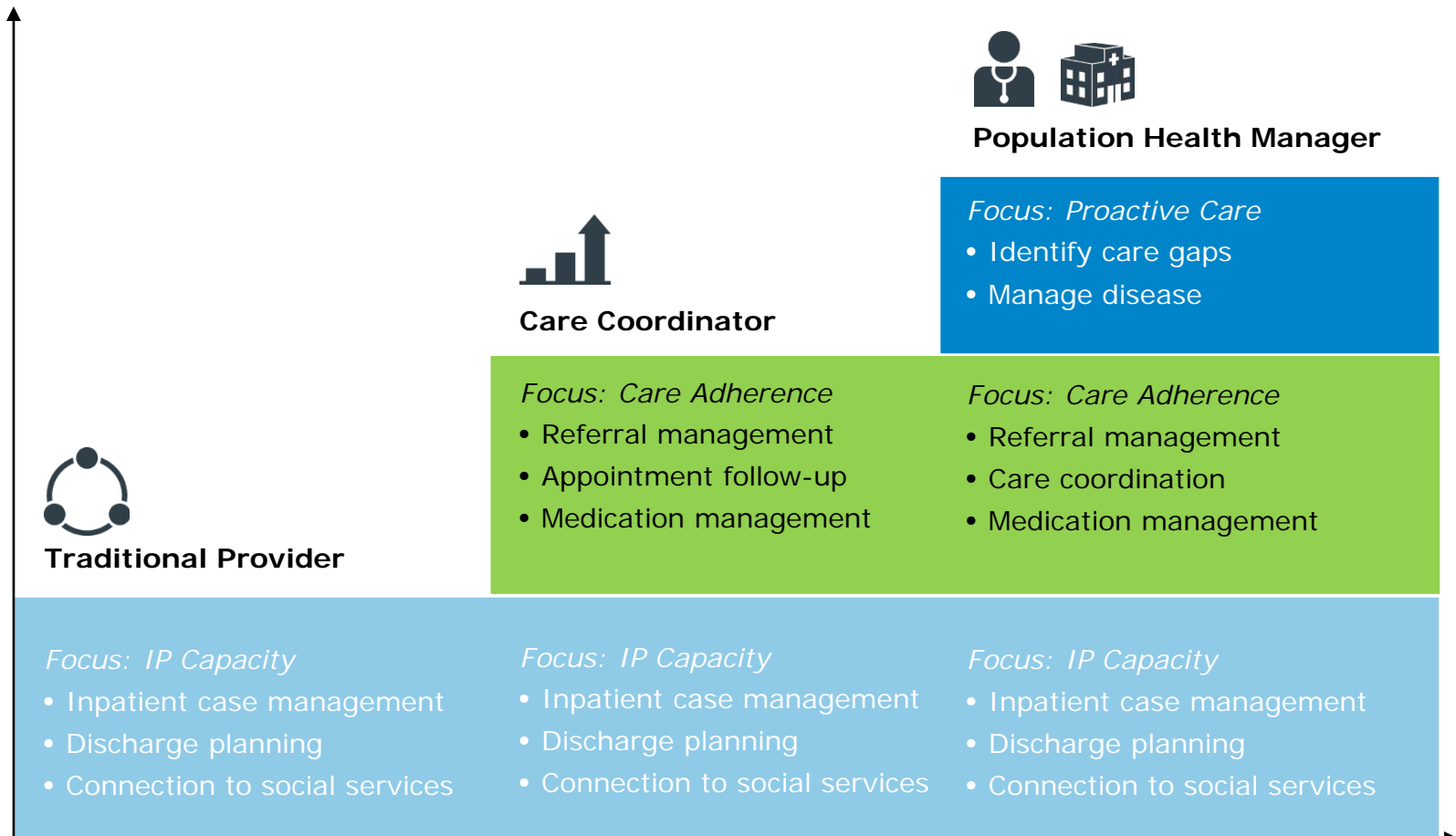
- Analytics
  - How to capture the data
  - How to review the data
  - How to identify trends
  - What to do with the trends
- Intervention opportunities
  - Education (for the member, provider, patient, Blue KC staff...)
  - Telephonics vs. in person vs. e-mail vs...
- Communication skills
- Identifying and addressing barriers



**As Providers assume greater risk, payers and providers must partner collaboratively and effectively, jointly planning population health strategies that work for the unique needs and capabilities of that practice or system.**

# Aggressively Taking on Responsibilities

## Expanding Provider Care Management Roles



**QUESTIONS?**

THANK YOU