Driving Transformative Change: Payer & Provider Partnerships in Population Health Management

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

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
Preventive Measure Set

Medical Home vs Non-Medical Home Performance
2014 & 2015

Breast Cancer Screening
- Non-PCMH Attributed Membership 2014: 74.50%
- PCMH Attributed Membership 2014: 79.77%
- Non-PCMH Attributed Membership 2015: 73.37%
- PCMH Attributed Membership 2015: 78.94%

Cervical Screening
- Non-PCMH Attributed Membership 2014: 74.95%
- PCMH Attributed Membership 2014: 78.12%
- Non-PCMH Attributed Membership 2015: 72.48%
- PCMH Attributed Membership 2015: 68.45%

Colorectal Cancer Screening
- Non-PCMH Attributed Membership 2014: 65.28%
- PCMH Attributed Membership 2014: 67.14%
- Non-PCMH Attributed Membership 2015: 57.21%
- PCMH Attributed Membership 2015: 68.45%
Chronic Care Measure Set

Medical Home vs Non-Medical Home Performance 2014 & 2015

- Diabetes - Blood Pressure level <140/90
  - 2014: Non-PCMH Attributed Membership: 63.96%, PCMH Attributed Membership: 71.45%
  - 2015: Non-PCMH Attributed Membership: 63.53%, PCMH Attributed Membership: 73.80%

- Diabetes - Eye Exam
  - 2014: Non-PCMH Attributed Membership: 50.36%, PCMH Attributed Membership: 54.84%
  - 2015: Non-PCMH Attributed Membership: 48.72%, PCMH Attributed Membership: 58.08%

- Diabetes - HbA1C <7%
  - 2014: Non-PCMH Attributed Membership: 37.32%, PCMH Attributed Membership: 40.16%
  - 2015: Non-PCMH Attributed Membership: 36.71%, PCMH Attributed Membership: 38.89%
Chronic Care Measure Set (cont.)

Medical Home vs Non-Medical Home Performance
2014 & 2015

- Diabetes - HbA1C NOT Poor Control: 42.48%, 45.48%, 64.92%
- Diabetes - HbA1C Testing: 90.21%, 91.77%, 94.47%
- Diabetes - Nephropathy: 81.62%, 88.55%, 88.89%

Bar chart showing performance metrics for Diabetes - HbA1C NOT Poor Control, Diabetes - HbA1C Testing, and Diabetes - Nephropathy.
Today’s health plan members are not the members we’ve covered in the past. They require more care management than ever.
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.