Population Health Management Primer

A White Paper

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What Is Population Health Management?

Population Health Management (PHM) is a term used to describe a system of care that focuses on ensuring that people receive the right care, provided by the right people, in the right place, at the right time. Fundamentally, it shifts the focus of health care away from episodic "sick" care to continuous and coordinated focus on the maintenance of good health. At the same time, the focus is shifted from the traditional model of care for the individual patient to evidence-based, high quality and high value care for populations of patients with similar conditions.

To be successful, a Population Health Management Program must not only identify specific populations and best practices for treatment of that population, but also work with individual patients to identify needs with respect to a wide range of factors influencing their health. This allows care teams to craft care plans with patients that truly reflect their needs and address the most critical drivers of their health.

Some of the key strategies that providers are using to better manage the health of a population include:

- Greater patient involvement in clinical decisions
- New community and payer partnerships
- Use of advanced technology to collect, analyze and report data covering a population

According to a Premier, Inc. white paper supported by The Commonwealth Fund, aggregated data on utilization, demographics, financial performance, quality scores and other metrics are necessary for Population Health Management. This information must be presented in a digestible and actionable format and linked across the continuum to support predictive modeling, targeted services, provider evaluations and patient intervention. With this data, providers can better understand the specific needs and risks of a population.

Why All the Rage?

It's simple really. We must change the way we have approached healthcare in the United States in order for healthcare costs to be manageable and sustainable.

According to the Commonwealth Fund report Mirror, Mirror 2014, the United States health care system is the most expensive in the world. You would think that our nearly twice the average spend per capita on health would buy us the best quality performance and health outcomes in the world. Not so. In fact, this report and prior editions consistently show the U.S. underperforms relative to other countries on most dimensions of performance. Among the 11 nations studied in this report — Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States — the U.S. ranks last, as it did in the 2010, 2007, 2006, and 2004 editions of Mirror, Mirror.

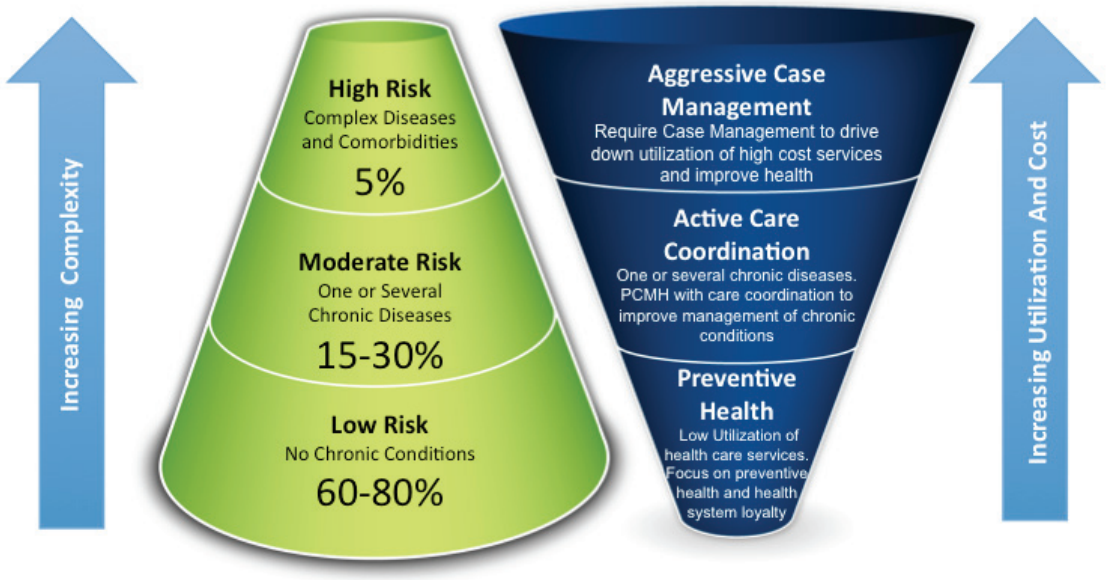
The fact that the U.S. ranks last or near last on dimensions of access, efficiency, and equity has led to a number of recent changes in the U.S. healthcare landscape. The

federal government has been gradually trying to take steps to facilitate changes in the healthcare industry that will improve our performance. Over the past several years we have seen enactment of the HITECH Act, with incentives to encourage adoption of Electronic Health Records in a meaningful way to improve healthcare quality, safely and efficiency, as well as the Affordable Care Act, making low-to moderate-income families eligible for financial assistance in obtaining health insurance coverage.

Population Health Strategies

Research of early adopters of Population Health Management Programs has provided significant insight as to successful strategies that balance the realities of need for high-value care with fiscal resource limitations. The most successful models implement a tiered approach to population health.

Generally speaking, the 5% of the patient population classified as **High Risk** (with one or multiple complex diseases and co-morbidities) make up a disproportionately large percentage of the health care expenditures. In this population, case management is frequently employed to proactively manage conditions and coordinate care to try to trade high-cost acute care services for low cost chronic management. Appropriate end-of-life care and avoidance of readmissions are also priorities.



For the **Moderate Risk** patients, or 15-30% of the total population, the focus is on improving care for chronic conditions. Often these patients are managed in a patient-centered medical home and frequently care coordination/care management services are used to improve patient engagement, self-management, compliance, and preventive health maintenance. Improved control of chronic conditions helps to improve patient overall health, and consequently leads to avoidance of higher-acuity and higher-cost services.

Finally for **Low Risk** patients, those with no or only minor health conditions, the focus is on preventive health and keeping the patient engaged and loyal to the health system.

Keeping the patient loyal to the health system not only improves the bottom line for the system, but it also helps to keep the patient's health-related data within the system, which improves the ability to analyze data to reveal which Low Risk patients have now become Moderate Risk patients with a need for increased services.

While health systems may choose to start their Population Health Management Program with attention to High Risk patients, attention to this sub-group alone is inadequate to achieve overall health expenditure savings. Tiered programming for all three groups is essential. Additionally, systems implementing multiple payer-specific programs have struggled to obtain adequate return on investment. A streamlined, consistent approach for each of the tiers is most effective.

The Changing Reimbursement Landscape

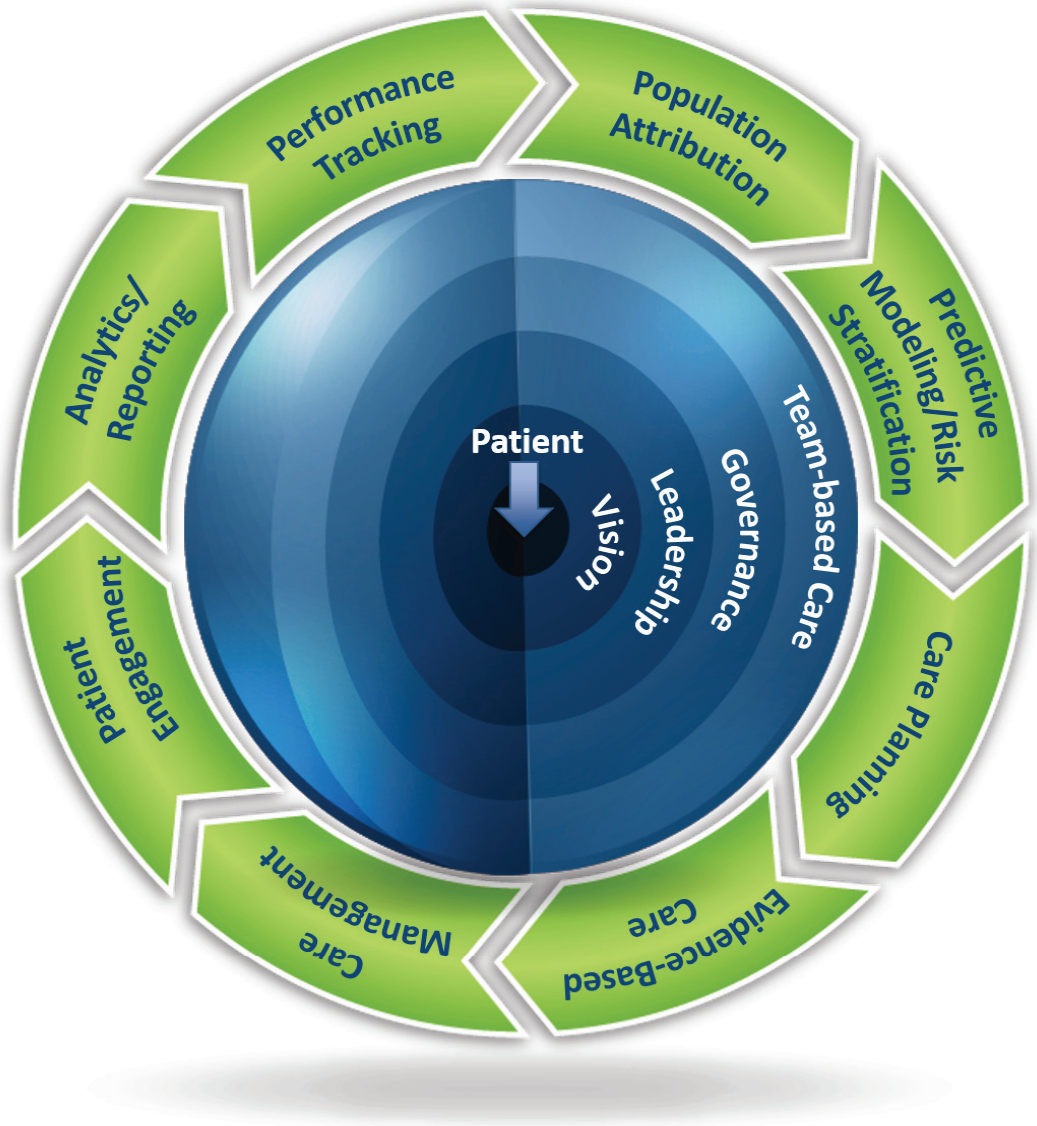
Reimbursement models have also been shifting in response to the need to bend the healthcare cost curve downward. In recent years health systems have engaged in relationships with payers with reimbursement models favoring a fee-for-service model with "pay-for-performance" incentives for basic quality improvement efforts. The last two years have seen dramatic changes to that model, with payers shifting more and more of their dollars to value-based reimbursement.

In the value-based purchasing model health systems must focus on reducing readmissions, decreasing unit costs by reduction in variation, and streamlining services as well as improving cross-continuum handoffs and standardizing care. The focus is more and more on avoidance of penalties rather than working for performance bonuses, as the expectations for "value" in healthcare increase. Responding to this new trend, many health systems are forming clinically integrated networks in preparation for full population accountability and preferred risk-based payer contracting, with the expectation of receiving bonuses based on total cost reduction.

An example of this type of relationship is the Medicare Shared Savings Program (MSSP), a CMS related Accountable Care Organization (ACO). In this program health systems or other health care organizations assume financial accountability for attributed Medicare patients. Medicare continues to reimburse the institution on a traditional fee-for-service basis, but at the end of the year if the institution has demonstrated cost savings from the expected Medicare spend for the attributed population, the institution gets to split the savings with CMS. There are over 500 MSSP ACOs now operating throughout the United States.

Elements of Population Health Management

Population Health Management is complex. It involves leadership and communicating a shared vision. It requires breaking down silos across the care continuum, transforming the healthcare service culture to team-based care, and developing new organizational structures and governance. It involves considerable investment in information technology and analytics, as well as a commitment to evidence-based care, reduction of variation, and engaging the patient in his/her care. In short, Population Health Management is an entirely new paradigm in U.S. healthcare delivery.



In its most basic form, Population Health Management requires the following four elements:

1. **Population Analytics and Reporting**
   One of the basic requirements of Population Health Management is the ability to access data about patient populations. Assimilating health and financial data from multiple sources into a powerful and central resource facilitates more informed, strategic decisions. Predictive modeling helps forecast which patients are likely to have significant health costs. Ultimately, getting actionable information to the point of care is the key to success.

2. **Population Outreach and Care Management**
   By identifying populations and sub-populations and placing patients into registries, providers can identify patients who might benefit from additional services. Examples of these groups include: patients needing reminders for preventive care or tests; patients overdue for care or not meeting management goals; patients who have failed to receive follow-up after being sent reminders; and patients who might benefit from discussion of risk reduction. Risk levels can be stratified and outreach done for patients at the level they require.

3. **Care Planning and Coordination**
   Developing evidence-based, longitudinal care plans and protocols allows non-physician care team members to take on much more of the care traditionally limited to physicians. Much of this work is being automated to maximize the efficiency of the care team.

4. **Patient Engagement**
   In an organization dedicated to Population Health Management, providers must care for patients between as well as during encounters. Care teams must strive to deliver appropriate, evidence-based care during patient visits, but they must also ensure that care gaps are addressed when patients do not come into the office. That requires motivating and collaborating with patients to help them take care of themselves. In addition to access to providers, patients can be engaged by Care Coordinators. Automated messaging and patient portals are also often used to engage patients. Home tele-monitoring and other telemedicine trends are rapidly emerging.

The importance of data and data analysis to enhance population health initiatives cannot be over-emphasized. In order to excel in Population Health Management, health systems must focuses on these key IT initiatives:

- Population identification through patient attribution
- Identification of care gaps through the use of decision support tools
- Risk stratification
- Cross-continuum care management
- Transparent quality and outcomes measurement
- Patient engagement tools

- Telemedicine
- Predictive modeling
- Health Information Exchange (HIE)
- Advanced disease registries
- Ambulatory EHR network
- Referral management
- Utilization management tools

In order to support these areas, systems often implement an enterprise data warehouse (EDW), which will integrate claims and clinical data to improve patient attribution, decision support, risk stratification, and predictive modeling. In addition, the system may utilize third-party software to assist in claims analysis and benchmarking. Ultimately, getting as much of this information back to providers at the point of care in a form that is actionable through the electronic health record is the key to affecting outcomes.

Population Health Terms

Patient-Centered Medical Home (PCMH)

The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system.

- **Patient-centered:** A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.
- **Accessible:** Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations.
- **Committed to quality and safety:** Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.

Medical Neighborhood

A Medical Neighborhood fosters shared accountability by linking specialty care and primary care physicians together to provide integrated, patient-centered care.

Patient Quality Reporting System (PQRS)

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments (i.e. penalties) to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment to practices with eligible professionals that satisfactorily report data on quality measures for Medicare Part B Fee-for-Service (FFS) beneficiaries.

Beginning in 2015, the program also applies a payment adjustment (penalty) to EPs who do not satisfactorily report data on quality measures for covered professional services. PQRS remains essentially a pay for reporting initiative and is expected to be phased out in favor of outcomes based strategies.

Accountable Care Organization (ACO)

The Accountable Care Organization concept is one that is evolving, but generally, an ACO can be defined as a collection of health care providers -- including primary care physicians, specialists, and hospitals -- that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients.

An ACO potentially could be formed around a variety of existing types of provider organizations. Many multispecialty medical groups, physician-hospital organizations (PHO), and organized or integrated delivery systems already function as ACOs or have the management and/or payment structure required to quickly evolve into an ACO. Other provider organizations, such as tightly managed independent practice associations (IPAs), are also likely candidates to become ACOs but some may require more time and/or infrastructure support to provide the care and cost benefits of an ACO.

Medicare Shared Savings Program (MSSP)

The Centers for Medicare & Medicaid Services (CMS) established a Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. The MSSP program is a very specific type of Accountable Care Organization (ACO) for Medicare Fee-For-Service patients.

The MSSP Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care. Currently this is a voluntary program and organizations initiating the program do not have down-side risk outside of the cost of implementing the program.

Care Coordination/Care Management/Case Management

Care Coordination

Care coordination is an information-rich, patient-centric endeavor that seeks to deliver the right care (and only the right care) to the right patient at the right time. It helps ensure that patients' needs and preferences for healthcare services are understood and that they are shared as patients move from one healthcare setting to another or to home, as care is transferred from one healthcare organization to another or is shared among a primary care professional and specialists. (National Quality Foundation)

Care coordination is foundational to high-quality healthcare.

Essential elements of care coordination include a written plan of care that anticipates routine needs and actively tracks up-to-date progress toward a patient's goals, and a communications "feedback loop" consisting of open dialogue among members of the care team, the patient, and his or her family. Care coordination also assures that care is not duplicative and is within prescribed parameters to assure cost effective and good outcomes. Services are frequently protocol driven.

Generally the term care coordination is used for intermittent services of lower acuity, often in the ambulatory setting.

Case Management

Case management is *a* clinical service focused on those individuals who are determined to need assistance with coordination of services; daily living skills; finding and maintaining housing, jobs and friends; and in some cases, a single long-term relationship with a professional caregiver or helper. Case management is provided continuously, even if there is no immediate need for services, so long as the individual is determined to need the assistance a case manager can provide. The goal of case management is the long-term recovery of the individual and increasing the ability of the individual to cope and function independently, including managing his/her own symptoms or addictions, and finding and maintaining his/her services and community living requirements.

Case management is generally used for high-risk patients in acute-care environments.

Care Management

Care management is a term that is frequently used interchangeably with care coordination. However, sometimes it used as the overarching term for all care coordination services across the continuum.

Care Management Strategies across the Continuum

Utilization Review

When a patient or care giver requests a service, the utilization review process uses level of care criteria for a patient presenting specific symptoms or behaviors to determine if the patient meets the criteria for the service requested. Typically, utilization review is done by persons other than the treating clinician or responsible service provider. Utilization review is usually required for those services that are particularly expensive or particularly intrusive, or services that a system wants to or is required to use less of or find alternatives to.

Clinical Integration

Clinical Integration is commonly defined as a health network working together, using proven protocols and measures, to improve patient care, decrease cost and demonstrate value to the market. Once the clinically integrated network can demonstrate a value proposition, payers and large employers are approached to support the network and other incentives that are based on achieving defined results.

Summary of Population Health Interventions

	High Risk	Moderate Risk	Low Risk
Model	▪ Case Management with single point of contact to coordinate all services	▪ Patient-Centered Medical Home (PCMH)	▪ Engage Patient with Patient Portal. Provide multiple access points
Support Services	▪ Home Health ▪ Pharmacy ▪ Community Services	▪ Group Visits ▪ Support Group ▪ Community Services	
Technology	▪ EMR ▪ Advanced Case Management with cross-continuum coordination ▪ Advanced Disease Registries ▪ Health Information Exchange ▪ Utilization Management	▪ EMR ▪ Care Coordination Module ▪ Registries ▪ Predictive Analytics ▪ Patient Portal	▪ Patient Portal ▪ Mobile Apps
Resource	▪ High Risk Case Manager	▪ Ambulatory Care Coordinator/Health Coach	
Network	▪ Clinically-Integrated Network of Post-Acute Providers	▪ Primary Care Patient-Centered Medical Homes and Medical Neighborhoods	▪ Expanded low acuity care access (retail or urgent care, tele-health)

About Impact Advisors

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Impact Advisors is a recognized leader in the healthcare IT industry. We stay attuned to the latest technologies and trends impacting our clients through our involvement with advocacy organizations, including the Scottsdale Institute, HIMSS and CHIME.

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