Keys to Achieving Population Health Management
Unsustainable costs, combined with gaps in care coordination and quality, have led to the large-scale efforts to redesign U.S. healthcare delivery systems and how care is funded. The traditional fee-for-service payment system, with its built-in incentives for more care, more testing and more expensive intervention has resulted in provider misalignment and lack of accountability. We have generally been in the business of “sick care.” But under recent federal legislative healthcare reform programs, most recently the Patient Protection and Affordable Care Act of 2010, new physician-provider-payer arrangements will be required in order to reduce healthcare costs and ensure improved quality outcomes.

One of the approaches healthcare providers are taking to fulfill the federal requirements is Population Health Management (PHM). If you were to ask 10 different people to define PHM, you might get 10 different answers. To put it simply, this is an industry term that means healthcare providers are responsible for caring for the health outcomes of defined groups (or populations) of patients. Physicians would no longer dwell in the mindset of caring only for individual patients in their waiting rooms, hospitals no longer with just people in its beds. It’s not just about the sick in this new era of reform. The new models provide interventions to address patterns of morbidity, reduce costs and help people stay well. The focus is on minimizing chronic conditions and less episodic care. The objective is to keep everyone healthy, and to do that requires healthcare providers to pay close attention to a defined population and coordinate their care. Trends will include community coalitions, narrow networks taking patients through the continuum of care and evidence-based payment models. And that’s what PHM is all about – the healthcare provider utilizing the right people and right resources, including technology, to provide better organized, more personalized and proactive care to all patients.

While there are many pieces that play a role in achieving PHM, three key highlights are:

- Risk Stratification of the High-Utilization Population
- Technology Platform for Care Coordination
- Patient Involvement

Risk Stratification of the High-Utilization Population

According to the Agency for Healthcare Research and Quality, 5 percent of patients are responsible for almost 50 percent of U.S. healthcare spending (2005). In order for healthcare provider networks to maximize their shared savings opportunities, it is essential to reduce the number of unnecessary in-patient admissions, emergency department visits, and interventional care and imaging services.
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Risk-stratified care management begins with a periodic and systematic Health Risk Assessment (HRA), using criteria from multiple sources to develop a personalized care plan. So as the industry shifts the focus from sickness to wellness, it will be essential to identify the chronically ill, high-utilization population and place them into meaningful categories for care management. The foundation of PHM will be to:

- Analyze historical data to identify patient populations with opportunities for reducing costs and improving outcomes.
- Develop a portfolio of intervention strategies to manage population risks.
- Create a rapid-cycle learning loop to drive continuous improvement.

Although the number of such diagnostically-related populations is endless, a few illustrative examples would include patients with Alzheimer's, unstable diabetes, asthmatic children with recurring ED visits or hip replacement patients on Coumadin.

At the recent Amerinet Executive Forum, Amerinet members and industry leaders gathered to discuss key elements of PHM and to review current successes by Amerinet members Intermountain Healthcare, OSF Healthcare, Samaritan Health Services and Virginia Mason Medical Center during a presentation and panel discussion. The panel discussion was moderated this year by healthcare futurist Ian Morrison. Morrison is the founding partner of Strategic Health Perspectives, a forecasting service for clients in the healthcare industry and the author of Leading Change in Health Care: Building a Viable System for Today and Tomorrow (AHA Press/Health Forum, 2011), and Healthcare in the New Millennium: Vision, Values and Leadership (Jossey-Bass, 2002). His previous book The Second Curve – Managing The Velocity of Change (Ballantine, 1996) was a New York Times Business Bestseller and Business Week Bestseller. The annual forum provides Amerinet members with the opportunity to meet with leading industry executives, government policy makers, as well as academic scholars to discuss the latest topics in contemporary and prospective healthcare issues, focusing on strategies, experiences and solutions that drive meaningful improvements to healthcare.

In a real-world example of how PHM can work, Amerinet member Virginia Mason Medical Center has worked with large employers to define clinical “products” that they defined as most necessary. They then worked to create continuum-of-care treatment plans around each of these products based on the purchasing specifications set forth.
by employers. These purchasing specifications included:

1. evidence-based care
2. patient satisfaction
3. same-day access
4. rapid return to function
5. affordable price for employer and provider

These five define a market standard for healthcare production, purchase and payment based on quality. Virginia Mason has produced 15 such products and has deployed these in a number of domestic markets.

Another example is Intermountain Healthcare’s practice they call “Hot Spotting” which involves proactive interventions to help individuals manage complex chronic illness. Intermountain Healthcare worked with its payer network to identify patients whose annual healthcare costs were in the top 10 percent and set up a Complex Care Clinic. The clinic includes a multidisciplinary team including doctors, pharmacists, care managers and psychiatric nurse practitioners to address medical, behavioral and social needs.

**Technology Platform for Care Coordination**

With the Primary Care Provider (PCP) as the nerve center of coordinating care management services for their entire panel of patients, a very robust IT system will be required in order to derive meaningful quality metrics and care guidelines. Changing clinical practice will require the support of powerful information systems. Data is critical. It will be crucial to have data management, analysis reports and performance dashboards to help providers enhance their care delivery, along with online portals with medical information for patients and clinicians to access. It will be important to not only collect the data and measures required for external reporting, but also help inform staff about clinical performance.

Unlike other industries that are highly reliant upon the implementation of meaningful data analytics, healthcare continues to be in its infancy with regard to quality metrics. Although mandatory data elements have been reported for the last decade on a limited group of diagnosis-related group (DRG) categories – Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN) – there remains a lack of scientific confirmation that improved patient outcomes are directly related to the metrics and subsequent patient care guidelines selected over past years. The appropriate weighting of each metric and the many DRGs with no related reporting requirements are just a few of the challenges of population health analytic science and business intelligence in healthcare.

Historically, healthcare payers have only had access to patient claims data while the provider relied solely upon the individual patient’s electronic medical record information. As we improve our ability to overlay population-level electronic medical records (EMR) and claims data through a robust technology platform, we will continue to see a more scientific understanding of the impact of our collective efforts around population health.

**Patient Involvement**

It is important to understand that patients also play a key role in helping to reduce the national trend of rising healthcare costs. Helping patients become educated healthcare consumers is a key element of PHM. This can be one of the more challenging aspects for healthcare providers as the high utilization populations with chronic and co-morbid conditions may have additional socioeconomic and psychological considerations such as limited education, substance abuse, lack of transportation and poverty that may hinder their involvement in self-advocacy. The future of healthcare in this regard will involve meeting patient populations “in their lives” and may be more social work than medical care.
Incentives such as gift cards, cash rewards and reductions in insurance premiums have been effective in drawing patients into a program, thus increasing the likelihood of the very essential active patient/family engagement and receptivity to coaching and general ownership of health maintenance practices.

Through its Holistic Care model, which focuses on integration and innovation to improve care, prevent disease and create value, Amerinet member OSF Healthcare formed a regional collaborative and partnered with local agencies, schools and churches to bring education and care into the community. The pillars of their model include:

- Specialists
- Hospital
- Home Health
- Nursing Home
- Community

Intermountain Healthcare provided an integrated wellness program with financial incentives to participate in their health risk assessment, while also recommending health coaching and other activities.

Many of these programs also include an internal component, as it is important for healthcare providers to “practice what they preach,” and cultivate a healthier workforce to deal with change and stress. Samaritan Health Services in Corvallis, Oregon, a key member of the successful coordinated care organization being built in the state, was named as one of the Healthiest Employers of Oregon in 2013 for its efforts in building a foundation for better healthcare through its more than 1,500 employees.

The scientific best-practices and metrics designed for each unique population will continue to evolve as the body of shared information expands over time, always moving toward a safer, more efficient, patient-centered and equitable approach.

Looking for “Best Practice”

At the end of the day, supporting the wellness needs of patient populations will require healthcare leaders to implement large-scale improvements in processes and technology to ensure efficient coordination. Additionally, leaders need to have a strong commitment to aligning their physicians, payers and employees, as well as their communities. To accomplish this as efficiently as possible, leaders should look to organizations with integrated solutions to deal with population health management. The process will likely be difficult and long term.

<table>
<thead>
<tr>
<th>Key Strategic Lessons to Build Upon</th>
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<td><strong>Short Term</strong></td>
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<td>Build cost and contract competitiveness to demonstrate value.</td>
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<td>Implement healthcare information technology and meaningful use solutions.</td>
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<td>Retain, acquire and onboard physicians.</td>
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<td><strong>Medium Term</strong></td>
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<td>Review the process of business model migration from a fee-for-service environment to pay-for-performance and shared savings.</td>
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<td>Assess risk and value. How far do you want to go and how fast do you need to get there?</td>
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<td><strong>Long Term</strong></td>
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<td>Create an enduring culture of quality and accountability.</td>
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<td>Adjust for the reimbursement changes to encourage the Triple Aim of better health, better patient care and lower costs.</td>
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<td>Movement towards a population health model, particularly in public programs.</td>
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Source: Ian Morrison, Strategic Health Perspectives
Within these strategies, best practice solutions should include:

- Identify at-risk patients; intervene, engage and evaluate: Reduce 30-day readmission rates.
- Own efficient, financially sound medical practices: Ability to analyze downstream revenue to hospitals from medical practices.
- Qualify physician practices for patient-centered specialty practice: Gain additional practice revenue as a result.
- Possess an integrated technology platform that connects disparate systems including long-term care and post-acute care: Allows for the connectivity and access to data to emphasize population health management.

The competencies that will define a successful PHM will include:

- Care automation
- Reduction in readmissions
- Cost and utilization measurement across the continuum of care
- Improved patient compliance, no-show rates and engagement
- Quality measure reporting
- Patient stratification and interventions targeted to the right people and populations

- Outreach and quality patient education
- Connectivity to community-based organizations

All of this does take enormous time and money, but costs and efforts can be minimized by not “recreating the wheel” but using integrated solutions available in the market. Despite the costs, the incentives surrounding the inevitability of value-driven healthcare are too powerful to ignore.

Amerinet and its partners offer comprehensive Population Health Management solutions that help identify and manage at-risk patient populations, match interventions and improve clinical and financial outcomes. You can access turnkey preparation guidance and support for primary care and specialty practices leading to successful Patient-Centered Medical Home (PCMH) Recognition and Patient-Centered Specialty Practice (PCSP) Recognition. Contact us today to learn more.

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