The Four Pillars of
POPULATION HEALTH MANAGEMENT
What is fueling the move to Population Health Management (PHM)? The shift from fee for service to value-based reimbursement is being fueled in part by the government and in part by payers. Physicians are increasingly feeling the pressure to be under value-based reimbursement arrangements and risk-based payment models. Therefore, healthcare providers and networks are going to look for solutions that can help them survive this change.

Any viable solution must help to identify and manage at-risk patient populations, match interventions and improve clinical and financial outcomes. But what are the essential building blocks of a strong population health management program? In this case, it can be looked at as four strong pillars anchoring the program:

- Planning and Strategy
- Network Development
- Practice Transformation
- Care Coordination
The Four Pillars of POPULATION HEALTH MANAGEMENT

PILLAR NO. 1: PLANNING AND STRATEGY

ARE YOU READY?

- Organization
- Infrastructure
- Healthcare delivery
- Payer partners

The transformation model begins with the strategy and planning required to navigate the local landscape of providers, facilities and payers to develop a clear path to success. As you build your processes and what your capabilities will be going forward, an important early step is to candidly assess the readiness of your organization:

- **Organization**: Is your organization itself progressive in terms of leadership? Are your potential partners ready as well?

- **Infrastructure**: Can your infrastructure support what the organization will need? What resources, in terms of human and dollars, will you need to support data exchange, timely communication with physicians and patients, and tools for tracking performance and costs?

- **Healthcare delivery**: What will be the basics of care coordination, the condition or population specific interventions involved and the level of patient engagement in care? Do they fit your strategy, care mission and strengths?

- **Payer partners**: What is the mix and involvement among commercial, Medicare/Medicaid and self-insured?

Once consideration has been made to move forward, Intalere partner Authentidate lists several critical success factors to successful adoption of a PHM program:

- **Objective clarity**
  - Analytics to identify population cohorts and impacts needing to be addressed.
  - Alignment with organization strategy.
  - Clarity in baseline and outcome expectation.
  - Active reporting against progress.

- **Sponsorship**
  - Passion for enabling health beyond the institution’s four walls.
  - Senior executive champions and willingness to act against outcomes.
  - Day-to-day management empowered to drive.
  - Leadership to drive the project forward.

- **Team**
  - Dedicated staff.
  - Leverage existing functions including discharge planning and community care.
  - Staff must not be afraid of technology.
  - Structured program management including roadmaps, communication and engagement models.

- **Solution**
  - Easy-to-use for patients and staff.
  - Enables intervention against vital signs, systems, treatment compliance and education.
  - Capture and transmit data in real time.
  - Configurable data and alerts to manage patients by exception.
  - Rapid innovation based on what works and what doesn’t for particular populations.

The process must be one in which learning, adjustment and growth are constant. Loopback Analytics focuses on a continuous process that includes:

- Identify at-risk patients through data-driven selection criteria.
- Match patients to appropriate intervention programs.
- Engage with eligible patients across the care continuum.
- Evaluate the process and clinical measures to support rapid cycle learning and continuous improvement.

![Loopback Analytics Diagram](image-url)
PILLAR NO. 2: NETWORK DEVELOPMENT

A clinically integrated network must be developed which includes primary care and specialty physicians, along with high-quality, low-cost facilities as part of a streamlined care delivery model. The network’s technology platform should be interactive at the point of care and automatically inform physicians which providers they should refer to and why.

Care is coordinated and/or integrated across all elements of the healthcare system including hospitals, home health agencies, nursing homes, etc., and the patient’s community (family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The Centers for Medicare & Medicaid Services (CMS) is currently testing many models, but whether it is an Accountable Care Organization, an Advanced Primary Care Practice Demonstration, a Comprehensive Primary Care Initiative or a private model, the key is coordination and collaboration across the continuum.

In terms of real world examples that are currently working in the community, a medical center in Lancaster, Ohio, served as the driver to bring together often competing healthcare entities from the home health, assisted living and long-term care spaces to work toward common goals. They were able to reduce readmissions, increase reimbursement and standardize care and procedures to help drive quality outcomes.

In another case, the Appalachian Agency for Senior Citizens (AASC) collaborated with four local acute care hospitals to develop the Appalachian Community Transitions (ACTion) program to improve health scores in rural Southwest Virginia.

The ACTion program is designed to provide a vital link between the acute care setting and the home/community-based supports that are crucial to avoiding hospital readmissions and keeping individuals healthy at home. ACTion coaches visit the patient in the hospital, complete a home visit with the client within 48-72 hours post discharge, and complete a minimum of three follow-up phone calls in a 30-day period.

An impressive 91% of AASC patients have avoided a hospital readmission in the 30-day period post discharge. Coaches work closely with hospital staff, creating a true team approach, which improves the quality of care for the patients by not having their care end when they leave the hospital. Coaches have been able to provide feedback to the hospital on ways to improve the discharge process to make it a better transition home for the patient.

PILLAR NO. 3: PRACTICE TRANSFORMATION

Experienced professionals, such as nurse practitioners and physician assistants, provide hands-on services that enable physicians and staff to begin making adjustments to patient flow and care delivery. Such adjustments help practices thrive in both fee-for-service and value-based payment environments.

As care becomes more integrated, practices must be of the mindset that, “we are the system.” Integration should mean:

- Standard clinical work
- Common culture/vision
- Shared incentives
- Team-based care
- Commitment to redesign for quality & efficiency
- Investment yields return

SOURCE: STUDER GROUP
In order to maximize value of the practice for both patients and partners, practices must leverage analytics to pinpoint areas where gaps exist. They must examine factors such as workflow, patient flow, medical record documentation and billing/collection methodologies to ensure operational efficiencies within the practice. This provides the structure and framework that allows practices to adapt to change quickly.

Rather than one-to-one encounters between patients and doctors, the physician will coordinate a “care team” utilizing their physician assistants, nurse practitioners and other professionals (health coaches, therapists, dietitians) to oversee a care plan of telephone calls, e-mail touchpoints, and group and community care.

Intalere member Intermountain Healthcare built a model of providing evidence-based care where leadership creates an infrastructure – data systems and clinical program – to measure and manage clinical performance. Clinical programs create care process models, educate providers and track outcomes in acute and chronic disease management and prevention.

As part of their formula, changing clinical practice requires the support of powerful information systems. Data collection focuses on those measures that share information on clinical performance, with many of those measures developed internally.

**PILLAR NO. 4: CARE COORDINATION**

Clinical outcomes are enhanced by tracking and communicating patient care across the care continuum, including transitions. Employing managers, nurses and nursing assistants to perform care coordination and utilization management is a key component of fully transforming a practice.

The bottom line is about keeping patients out of the hospital and from being readmitted, and making sure they’re on a care plan to stay healthy, because that is where the real costs (or penalties) come in now. Across the continuum, the ability to bring together disparate sources of data and turn them into useful information is a critical part of the process. This information should be analyzed and communicated across the entire integrated network of providers and facilities to promote continuous quality improvement, thereby further decreasing the overall cost of care.

Intalere member Verde Valley Medical Center, a 99-bed facility with 11 senior behavioral clinics located 15 miles from Sedona, Ariz., like many similar facilities throughout the country, was struggling with how to reduce readmissions in its facility. Realizing it would take a concerted, integrated effort, especially in a relatively rural setting, they began the process of community integration, instituting quarterly meetings that included membership from local skilled nursing facilities, assisted living facilities, durable medical equipment providers, hospice, home care, acute rehab, senior centers and care agencies to help ensure smoother care, coordination and movement between inpatient and outpatient settings. The teams were divided into three units: Strategic, Discharge Planning and Education. They initially discussed their challenges and barriers and how they could coordinate better quality of care enhancement for patients.

One of the first pillars of the program was the establishment of a Transitions of Care program through the formalization of a relationship with the Verde Valley Caregivers group, a 300-400 strong volunteer network that assists 20 new
patients per month. They visit the patients in the hospital and within 24 hours of discharge, and perform tasks such as med reconciliation and home safety checks, while providing transportation to follow-up appointments, therapy, dialysis, etc.

Verde Valley also established the CHF (Congestive Heart Failure) Wellness Program, a six-week multidisciplinary outpatient heart failure teaching and exercise program for all heart failure patients. It provided early identification of heart failure patients presenting to the emergency department or early after admission and involved an advanced practice nurse for patient management and long-term follow up, including telemedicine services. Readmits for CHF have consistently been below 2%, with a 0% readmission rate during many months.

Another pillar of the program was the Community Care Network which focuses on patients at risk for readmission and frequent emergency department visitors. It uses a volunteer health coach to visit patients after discharge, involves telemedicine technology in many cases and the engagement of a nurse practitioner, who teaches healthcare coach classes and serves as a liaison between the primary care physicians and patients in their homes.

In addition, Verde Valley added a Discharge Clinic to see patients within five days of discharge, a practice meant to further reduce the time to see a practitioner, assess any potential issues and further prevent readmissions. This was done, in part, after a root cause analysis of readmits revealed the average number of days between the admission and readmission was six days and that more than 55% of patients waited greater than seven days for an appointment. There was also a discharge nurse added to the process to support the discharge process and engage the scheduling department to schedule follow-up appointments at time of discharge.

Over the course of 19 months the all cause readmission rate at Verde Valley went from 11.7% to 6.4%, a nearly 50% reduction. In terms of Medicare Part A and B patients, the readmit rate went from 8.2% to 2.6%.

IN CONCLUSION
Supporting not only the healthcare, but also the wellness needs of patient populations will require healthcare providers to put into action comprehensive enhancements in their processes and technology to guarantee effective delivery of quality services. Additionally, they will need to be committed to alignment with their physicians, payers, employees and patients, as well as their communities. To accomplish this goal, providers must engage organizations with integrated solutions to help implement and manage a population health management program.

CONTACT INFO
info@intalere.com
877-711-5700

ABOUT INTALERE
Intalere’s mission focuses on improving the operational health of America’s healthcare providers by designing tailored, smart solutions that deliver optimal cost, quality and clinical outcomes. We strive to be the essential partner for operational excellence in healthcare through customized solutions that address customers’ individual needs. We assist our customers in managing their entire spend, providing innovative technologies, products and services, and leveraging the best practices of a provider-led model. As Intalere draws on the power of our owner Intermountain Healthcare’s nationally-recognized supply chain expertise and leadership in technology, process improvement, and evidence-based clinical and business best practices, we are uniquely positioned to be the innovation leader in the healthcare industry.

INTALERE
Two CityPlace Drive, Suite 400
St. Louis, MO 63141
877-711-5700
intalere.com

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