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What to Know Now
About Population Health Management

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INTRODUCTION TO POPULATION HEALTH MANAGEMENT

Improving population health is one of the "Triple Aims" of the Affordable Care Act and is the key to attaining the other two requirements: improving the patient experience (quality and satisfaction) and lowering the per-capita cost. Population health management (PHM) is defined as the use of clinical, social and personal information to manage the health outcomes of a group of individuals.

The goal of PHM is to keep a patient population as healthy as possible and minimize the need for expensive interventions such as emergency department visits, hospitalizations, imaging tests, and procedures[1]. PHM also redefines healthcare as an activity that encompasses far more than sick care. Instead of episodic care where providers treat ill patients, care would be defined as that which addresses the preventive and chronic needs of every patient, modifying the factors that make people sick or worsen their illnesses.

While not a part of the definition itself, it is understood that population health outcomes are determined by many factors beyond medical care, such as public health, genetics, behaviors, social factors, and environmental factors. In fact, according to a study done by the University of Wisconsin Population Health Institute in 2010, medical care accounts for only 20% of a patient's health. The remaining 80% is made up of social economic factors, health behaviors and environmental factors.

Many see attention to population health as a great opportunity for health care delivery systems, public health agencies, community-based organizations and others to work together to improve health outcomes in the communities they serve[2].

THE ROAD TO IMPROVE POPULATION HEALTH

Over the last few years many health care practices and organizations have spent time and money participating in numerous government health care initiatives (PQRS, eRX, EHR Incentive programs, etc.), private insurer initiatives, ACOs and patient-centric homes. These externally-driven programs represent initial steps toward improving the population's health at a reduced cost.

The next steps are up to the care givers. The MGMA (Medical Group Management Association) believes that population health management success depends on a provider organization's ability to understand its processes and patient base to deliver the best care and adapt to the changing healthcare environment.[3] The need to keep patient populations healthy is part of the new care models being implemented as part of payment models that incorporate financial risk-taking and incentive management. What these changing models share is the move to coordinate consumer care not by the type of clinical problem, but by the type of specific consumers and consumer needs – the transformation of a horizontal care management system to a vertical care management model.[4]

Understanding and managing your patient population is, or soon will be, critical to managing your organization's finances while improving patient outcomes. In the beginning, the potential benefits, along with the capabilities the organization has to reach those benefits, must be assessed. The organization must understand the PHM process,

[1] "Population Health Management – A Roadmap for Provider-Based Automation in a New Era of Healthcare," *Institute for Health Technology Transformation*, 2012
[2] Stoto PhD, Michael, "Population Health Care in the Affordable Care Act Era ," *Academy Health*, February 21, 2013.
[3] Lahlou, MD, Ayoub, "Is PHM Right for your Organization?," *MGMA Executive View* , Winter 2014
[4] Oss, Monica e., "The Brave New World of SMI Population Management – New Care Coordination Model, New Financing Model," *Open Minds*, February 16, 2015.

risk-based contracting with insurers and what risktaking means at all levels. The organization must know what a population of healthy people looks like, how clinical risk is defined, how financial risk is measured, and the metrics used to analyze how patients with chronic disease get sicker or improve their illness.[5]

As one can see, instituting mechanisms to improve population health is very complex. But there are two basic components where even small practices and hospitals can begin to make improvements and participate in the new care models: (1) changing how you manage your patient population and (2) understanding your patient population.

CARE MANAGEMENT – CHANGING HOW YOU MANAGE YOUR PATIENT'S CARE

Care management is foreign to many aspects of our current health care system but it is where the "new world" of healthcare is headed. Providers, once they begin tracking their patient population, are surprised by the number of patients who have uncontrolled chronic conditions, or how many patients have not had timely colonoscopies, mammograms, flu shots or vaccinations. These are called gaps in care and they are bred by our episodic delivery of care. Monitoring patients who receive and do not receive these preventive services can go a long way toward keeping patients healthier.

Much of this monitoring will include managing social factors. Why do patients not see their physicians or why do they not follow their physician's orders? Factors such as difficulty with understanding the English language, not understanding a provider's recommendations, affordability of prescriptions and recommended food, all contribute to patient non-compliance and sicker patients. Care management of these patients consists of medical staff meeting patients where they are and ensuring they understand what is prescribed for them and why.[6] This can include scheduling follow-up services at the time of the appointment, follow-up phone calls to ensure patients are complying with a physician's orders, etc.

Even CPT billing codes have made way for managing patient care with the addition of codes for care management services, inclusive of non-face-to-face services, and transitional care management services. These codes include establishing, implementing, revising or monitoring care plans, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan and prognosis.[7]

Good care management includes stopping patient leakage where patients seek care externally. Once the patient steps outside the practice or clinic without notice to their physician, care of the patient becomes disrupted. Understanding how to hold on to your patients, retrieving those who have left and understanding why they left, enables a practice or clinic to not only focus on good medical care but also allows the practice to reap the financial rewards of a good patient base..

[5] Cassidy, MPA, Bonnie, "Population Health Information Management Presents a New Opportunity for HIM," *AHIMA*, August 2013
[6] Grimshaw, Heather, "Opening New Doors," *MGMA* Connection , March 2014.
[7] American Medical Association, CPT *Manual* 2014, 2015.

DATA ANALYTICS – UNDERSTANDING YOUR PATIENT POPULATION

If care management leading to a healthier patient population is the goal, how do providers get there? In order to change the direction from episodic and fee-for-service to better population health and valuebased care, PHM requires some new skill sets and new infrastructures for delivering care.

Patient data can tell a practice or clinic much about their patient population, such as their hospital admissions, transfer and discharge summaries, pharmaceutical and patient reported data. Patient data may be assembled in various ways – through claims, EHR or other automated programs. Whether your practice, clinic or hospital can afford automated systems to track data or you start small by manually organizing and charting patient data, you should begin gathering the following information to support your PHM functions:

- Population identification
- Target the patients the practice should focus on, including which issues related to a given patient should be focused on,
- Identification of care gaps
- Determine whether particular providers are practicing at the expected performance level,
- Determine whether any cost problems are due to excess utilization,
- Patient engagement, and
- Measure outcomes

Data analytics are only useful if physicians and other providers understand what the results mean and incorporate those results into the workflow so they are present when a clinician is with the patient. Data can be monitored on a large, organizational scale and on an individual, physician-to-patient level.

The data must be clean and accurate, especially if it is going to be used in reports about provider performance and patient outcomes. The same data analysis that is used in PHM can be reused for programs such as CMS' Physician Quality Reporting System, the Medicare and Medicaid EHR incentive programs, health plan pay for performance programs and patient-centered medical home recognition programs. In order to do this, the performance measures used in PHM should be aligned with the payment programs' metrics.

WHERE DO WE GO FROM HERE?

Population health management is still evolving and while some early studies show improved clinical outcomes, financial success and cost reduction is yet to be seen. Good leadership, getting all staff on board and setting targets for what the organization is trying to achieve are all essential.

For a PHM program to be effective, there is a need to focus on the data and information that will influence clinical and financial decisions, including entering into risk-based contracting. By gathering the appropriate information and eventually applying technology and automation to every aspect of population health management, provider practices and health systems should have an easier time transitioning from episodic/fee-for-service care to population health/value-based care.