Making the Most of Population Health Efforts

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What gets rewarded also gets people’s attention, such as last year’s historic HHS announcement that by the end of 2018 it would like an ambitious 90% of traditional Medicare payments transformed into value-based reimbursement, through accountable care organizations, bundled payments or hospital quality programs. As recently as 2011, Medicare made almost no payments through alternative payment models.

For providers, if population health wasn’t already a strategic mandate, it likely is now. Readers of HealthITAnalytics.com earlier this year tabbed population health management their top health care management issue, surpassing even “improving clinical care and patient safety.”

The HealthITAnalytics survey results are intriguing, considering that clinical care and patient safety are key components of most organizations’ comprehensive population health efforts. Besides highlighting industry interest in population health, these results point to the need for organizations to be explicit in their “population health” definitions, based on their community needs. Organizations must first specifically define population health

for themselves before they can determine how to most effectively implement population health measures.

Defining "Population Health"

Job one for many organizations is coming up with a common definition of "population health" that everyone — administrators, clinicians and external partners — can agree on. There is no industry standard for "population health." It often depends on the size of your community, and the characteristics of your target population. One certainty, however: targeting population health becomes even more challenging if key parties are all over the map with their definitions. As a reporter at HIMSS15 noted, while it seemed like nearly every HIMSS15 vendor "was trumpeting 'population health' in one form or another," it became eminently clear "that defining population health depends on whom you ask."

An industry standard for "population health" would be nice, but it's not realistic due to community variances. Instead, strive for a definition that works best for your organization, which may differ from others' definitions. The input sources for your definition may include other organizations in your referral/care coordination process, such as area hospitals, health plans, physician groups, public health agencies and rehabilitation care agencies.

One clear, comprehensive and community-centric definition of population health comes from David C. Pate, MD, JD, president and CEO of St. Luke's Health System (Boise, Idaho): "Population health encompasses the programs, services, tactics and initiatives that a population health manager (e.g., a health system or an accountable care organization) utilizes in order to assume the accountability for the outcomes of care and the cost of that care for an entire population or sub-population of people, only some of whom may currently be patients."

Whatever population health definition makes the most sense for your organization, it's important to consider the definitional impact across your care continuum and involve all participating organizations and patients. Hospitals, for example, should develop population health programs that consider the whole needs of their patients and how these patients navigate through their care both inside and outside of their care facility.

Implementing Population Health Standards

Whatever you're hoping to accomplish with your population health efforts, you'll likely hit some inherent obstacles right away, including:

• Insufficient patient care coordination – Despite powerful and effective new care coordination technologies, patient care coordination still relies heavily on system interoperability and human interactions.

• Clinician non-compliance – Sometimes, this occurs due to a lack of communication and education.

• Lack of patient engagement – Getting patients to adjust long-standing dietary and lifestyle habits, take prescribed medications correctly and reduce over-utilization is often a never-ending effort.

• Community resource disconnect – This may be due to insufficient external resources, unawareness, a lack of technology, a lack of prior connectedness to build trust and/or the absence of a compelling, win/win reason for partnering.

• Data barrage – For many organizations, the problem may be an overabundance of data and, more critically, sound data analysis.

Rather than simultaneously tackling all of these population-health related challenges, most health care systems are best served by sequentially focusing their attention and resources on a single, pressing community health need. That's what a large health system (and Freed Associates client) recently did to reduce re-admissions for high-risk patients age 65 and older discharged without home care from an acute stay in two of the system's hospitals.

This readmission reduction effort focused on creating an implementation strategy for post-discharge telephonic support via a centralized patient services call center, including compliance with care standards. Through this system, registered nurses and pharmacists would provide patients with up to 30 days of post-discharge telephonic support. After five months, the program was shown to reduce readmissions at one hospital from 24% to 14% and at the second hospital from 29% to 21%.

Effective Population Health Approaches

What works when approaching population health? Again, an effective population health solution must be tailored to your organization, and will likely include some or all of the following measures. Note that while the depth and degree of fulfillment for each of these measures is up to your organization, know that organizations demonstrating the highest level of population health performance typically execute well on all of these.

• Clinical outcome assessment – Collecting and measuring performance scores and analyzing clinical outcomes. The goal here is to use such metrics to improve quality, cost and efficiency of care at both the individual and overall levels.

• Data aggregation – Aggregating all data across the care continuum, including clinical applications, claims, administration, remote monitoring, mobile applications and more.

• Clinical/financial analysis – Combining and analyzing per-patient clinical and financial data, including diagnoses, prevention and treatment, as well as wellness and maintenance efforts.

• Risk identification – Determining, based on individual patient risk analyses, what patients are at greatest risk for adverse health outcomes and targeting health education and management efforts toward such individuals. This also mean identifying risks for a designated population, and identifying potential interventions, like wellness management and prevention, targeted toward moderate- and low-risk populations to ensure that these groups do not move up the risk pyramid.

• Intra-organizational communications – Ensuring that all relevant population health-related efforts and results are properly communicated to key administrative and clinical staff members.

• Return on investment assessment – Assessing the cost and return of population health measures, and tracking the ROI and risk arrangements.

• Community resources assessment – Checking on community resources available, identifying gaps in resources, and addressing these gaps as necessary to achieve optimal population health-related outcomes.

For any population health initiative, selecting, implementing and maintaining the proper technology is vital for supporting the continuum of care, to ensure effective development and execution of treatment plans and managing patient compliance. For example, Freed partnered with a large medical group to implement an electronic care management application to reduce paper processes and move toward building an automated, integrated care management model that would meet the demands of the group's future business and industry requirements.

With Freed's input and support, the organization designed, configured and implemented its new electronic care management system, which now enables care managers to more quickly and efficiently document inpatient and outpatient cases online, providing clinicians and team members with immediate access to this information. This led to revised workflows, optimizing a team approach to patient care and providing managers with greater visibility into care manager workloads and work flow, as well as offering users improved access to patient documentation and clinical history.

Conclusion: Leadership Matters

Start with your organization's definition of population health. Align your population health efforts with your overall strategy. Both internal and external organizations require strong leadership to champion the efforts, clearly define and articulate them, and remain visible in all aspects of the initiative. Engage all levels within your organizations, and those of your partners, with clear goals and outcomes. Build relationships so that people can work productively together. Develop a program and plan and obtain buy-in.

Focusing your population health initiatives on the highest level of effort — e.g., "this is all about the patients" or "this is all about our community's health" — will engender greater trust and cooperation in your efforts than by identifying the gaps. Whether those you're seeking to appeal to are on the administrative, clinical or community side, they'll be far more receptive to your efforts if you focus on elements of universal buy-in and agreement, such as maintaining optimal community member health.

