

Population health management: Shifting the care delivery paradigm

Overview

Fueled by health care reform, especially the shifting focus from pay-for-procedure to pay-for-performance, America's health care delivery system is undergoing monumental changes.

The roadmap for change has been shaped by two primary pieces of legislation:

- HITECH Act of 2009 that authorized up to \$19 billion in federal subsidies to physicians and hospitals for the Meaningful Use of electronic health records.
- Patient Protection and Affordable Care Act of 2010 that created demonstration projects to measure the value of patient-centered medical homes and payment bundling and created shared-savings accountable care organizations under the auspices of Centers for Medicare & Medicaid.

The resulting changes to reimbursement and the emphasis on automation, connectivity and accountability have directed efforts from the provider community toward reducing costs and improving quality and caring for the health of a defined population rather than providing acute care to an individually compromised patient.

There's no question that for health care organizations, inertia is not an option. However, the organizational challenges and the financial and human resources costs to manage the change required of the organization's culture in order to successfully participate in the new world of health care are substantial. The future of health care hinges on the ability of all stakeholders – providers, regulators, payers and patients – to embrace the new ideology of collaboration rather than competition.

This will, of necessity, demand that all stakeholders have a shared vision – moving away from paying for episodic sick care through a fee-for-service model to a model that rewards participants for keeping people healthy and costs down.

Thus, the rapid paradigm shift that has occurred toward adoption of a culture centered on population health management. Even the largest health care organizations who made the greatest progress in their population health journey agree that the journey toward population health management will require hard work, intense focus and commitment to make change happen.

What is population health management and why is it important?

According to *Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare*, a report issued by the Institute for Health Technology Transformation in 2012, a commonly accepted definition of population health is, "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." The report points out that in addition to medical care, a myriad of factors impact the health of a population – public health resources, the social environment (income, cultural beliefs, education, social support systems, employment), the physical environment (clean water and air), urban infrastructure (design, transportation, etc.) and individual choices and behavior and genetics.¹

The Care Continuum Alliance proposes that the population health improvement model is comprised of three components: the central care delivery and leadership roles of the primary care physician; the critical importance of patient activation, involvement and personal responsibility; and, the patient focus and capacity expansion of care coordination provided through wellness, disease and chronic care management programs.²

Where does the hospital fit in the population health management puzzle?

In its April 2012 report, *Managing Population Health: The Role of the Hospital*, the American Hospital Association said that

population health resides at the intersection of three distinct health care mechanisms:

- ▶ Increasing the prevalence of evidence-based preventive health services and preventive health behaviors
- ▶ Improving care quality and patient safety
- ▶ Achieving advanced care coordination across the health care continuum.

According to the report, challenges to hospitals' ability to successfully adopt population health include the lack of funding to pursue population health initiatives from the current volume-based system of care and the broad scope of the entire concept, from the physical environment to social structure to resource allocation. Hospitals may find it difficult to identify which population health factors they can directly impact with their limited resources. The good news, according to the AHA report, is that a survey of its members revealed that 98% of the CEO respondents believed that at some level hospitals should investigate and implement population health management strategies.³

Putting the pieces together

Population health management is rooted in one over-arching concept – managing the health of a group of patients, not just treating individual patients with diseases. Inherent in this concept is the commitment to disease prevention through education and behavior change. An organization that achieves optimal outcomes and appropriate utilization of services at the lowest costs possible has designed a comprehensive care delivery model that focuses resources on the right person or group of people with common health challenges, with the right engagement, at the right time, in the right place. Population health must involve a cast of players including employers, providers, patients, payers and others. Partnerships and collaborations between former competitors and non-traditional players will increase in the future as organizations build their capacity to effectively share responsibility and reimbursement for patient outcomes and satisfaction, data collection and analysis, member education and engagement, and a laser-focus on at-risk populations.

Cultural change – the foundation of population health management

How tall an order is it for health care organizations to prepare for successfully engaging in population health management?

The analogy of turning a ship around comes to mind. While many organizations have made great strides toward changing their cultures, a large number have not.

The current culture of current health care delivery features:

- ▶ A focus on treating individual sickness
- ▶ A passive patient who accessed the health care system periodically for episodes of illness or injury, were generally shielded from the true costs of care and who were usually compliant with their physicians' recommendations and took scant interest in helping to maintain their overall well-being beyond the acute episode
- ▶ A tendency to practice defensive medicine – over ordering diagnostic tests and over performing treatment procedures
- ▶ Being reimbursed for the number of procedures performed
- ▶ Delivering care in silos – hospital, physician, insurance company, post-acute care providers – uncoordinated care
- ▶ Competition among providers
- ▶ Limited use of data for quality improvement and revenue cycle enhancement
- ▶ The idea that occupied beds are good

The new culture of population health management demands:

- ▶ A focus on the health of a population
- ▶ An engaged patient who actively participates in keeping him or herself as healthy as possible, stays informed about individual health challenges and shops for the best value for his or her health care dollar
- ▶ An emphasis on prevention and keeping the population well
- ▶ Appropriate utilization of services including acute care diagnostics and treatments and post-acute care services
- ▶ Being reimbursed for overall quality of care and outcomes in a risk-based arrangement
- ▶ Delivering care seamlessly across an entire episode of care
- ▶ Collaboration among providers resulting in well-coordinated care
- ▶ Leveraging the power of “big data” to identify and understand populations and to establish strategies to mitigate risk and maximize potential returns
- ▶ Keeping people well, and out of the hospital

To say that most health care organizations have capability gaps with respect to new models of care delivery, especially population health, is an understatement. While most organizations report that they have begun to look at population health, the Healthcare Financial Management Association's *2011 Value Project Current State Survey* revealed that less than 20% of respondents said they had experience with designing and implementing population health programs.⁴

Many organizations are jumping into population health via accountable care organizations. ACOs have been promoted as a possible solution to rising health care costs while promoting care coordination. The Health Research & Education Trust in partnership with the American Hospital Association issued a report, *Hospital Readiness for Population-based Accountable Care*, in May 2012. The report identified broad gaps in health systems pursuing accountable care:

- ▶ While a high percentage of accountable care organizations employ some care coordination strategies such as medication reconciliation, relatively few use risk stratification and other care coordination activities including primary care setting case managers, aggressive patient activation and engagement strategies, intense chronic disease management program and patient-centered medical home models.
- ▶ As new accountable care organizations are formed, payers are establishing innovative payment arrangements in an effort to create financial incentives for high-quality care. These arrangements include shared savings programs, agreements between clinically integrated delivery systems and private health insurance providers focused on value-based purchasing and some type of risk arrangement model.
- ▶ Approximately one in 10 hospitals participating in or preparing to participate in an ACO do not have a financial risk management plan in place. Almost two-fifths of hospitals participating in an ACO and more than half of hospitals preparing to participate in an ACO do not feel they have the financial strength requirements to accept risk. This is especially troubling since a large percentage of the respondents also said they expect a significant increase in revenue sources from risk-based payment arrangements such as bundled payments for hospital and physician services and capitation.
- ▶ Respondents expressed significant degrees of challenge when it comes to working with physicians. Reducing clinical variation, aligning incentives for productivity and appropriate utilization of services, motivating physicians to participate, resolving issues between primary care and specialty physicians and developing physician leadership were all cited as opportunities hospitals needed to address and resolve in order to successfully participate in population-based accountable care.
- ▶ Developing and maintaining a common accountable care culture, developing the necessary clinical and management information systems, accessing start-up capital and establishing an effective governance structure were also cited as major challenges for respondents.
- ▶ All of these gaps in organizational infrastructure are of concern as respondents attempt to increase the number of individuals in their overall patient population.⁵

Health information technology powers the population health model

There is no doubt that to have any hope of success, organizations involved in population health management must get their arms around the voluminous amounts of data that is available to them. A solid IT platform is a must-have. Providers often complain about the high costs they must bear to create the necessary infrastructure to drive positive performance. The fact is, most health care providers, including physician practices, are already shouldering substantially higher costs to acquire and implement new IT capabilities. It's simply a cost of doing business in the new health care environment. The key to success is creating a platform that ties providers together to link data systems, especially electronic health records, from physicians, hospitals, non-acute care providers and other resources.

A health care organization's IT arsenal must also include tools to evaluate and analyze data repositories including claims data, patient registries, external report cards and more to gain the insight required to identify risk-mitigating interventions for sub-sets of the population. An intimate knowledge and understanding of its population's global health challenges and concerns and targeting opportunities with sub-sets such as those with diabetes and other chronic conditions create a win-win scenario for the organization and its patients. Rather than building these capabilities internally, many organizations are turning to outside expert resources to shore up their IT capabilities.

Bottom-line issues for top-line results

A culture committed to effectively managing the health of a population must rely on the power of big data, the positive results achieved from effective networks and continual learning from new knowledge and new expertise. In a nutshell, here's the reality for health care organizations operating in the new population health environment:

- ▶ Revenue and margins continue to be under pressure requiring health care organizations to drive down cost while developing new partnerships and innovative models of care.
- ▶ The future hospital/health care system will look different: utilization will change as accountability for defined patient populations expands. Building and integrating neighborhood health and virtual visit “sites” are critical for access and engagement. Organizational infrastructure must change in order to support a culture committed to population health.
- ▶ Understanding consumer behavior and choice will be keys to success. It's time for consumer insights to finally arrive to health care.
- ▶ Population health management is an exercise in agility and perseverance. Learning from early adopters is critical.
- ▶ Big data is becoming a technology burden. Getting to meaningful insights takes time and significant resources – it's becoming an impetus for consolidation.
- ▶ Non-traditional partnerships are growing. Short-term expansions create long-term operational and management complexities.

Your journey toward population health

Recognizing the challenges that population health management presents, health care organizations need a focus on helping their organization assess its current culture. Then they must devise strategies and actions to facilitate change management and foster a culture that engages in population health management. Concurrently, organizations need a focus on measurement to ensure their technology capabilities support robust quality performance measurement and reporting across the continuum of care.

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¹ Institute for Health Technology Transformation, *Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare*, 2012; page 8.

² The Care Continuum Alliance, www.carecontinuumalliance.org/phi_definition.asp

³ American Hospital Association, *Managing Population Health: The Role of the Hospital*, April 2012; page 4.

⁴ Healthcare Financial Management Association, *2011 Value Project Current State Survey*, April 2012; page 20.

⁵ The Health Research & Education Trust in partnership with the American Hospital Association, *Hospital Readiness for Population based Accountable Care*, May 2012.