The idea of population health management is not new. For decades, payers and others financially responsible for care have stratified populations to match needs and workflow with intensity of illness and need for care coordination. Methods used include analyzing claims data to identify at-risk individuals and deploying provider risk-sharing programs to reduce the future cost of care for those identified individuals. Often referred to in the payer world as “care management” or “disease management,” population health management has been both admired and questioned.

Studies show population health management (PHM) as both effective and ineffective in its ability to impact the cost of care. Why? What can you do to ensure successful management of patient needs across the spectrum of disease severity? This paper aims to answer these questions and offer a specific framework for action.

The Bottom Line: Community Wide Care, Real-time Information and the Cloud Make Population Health Management Work

Programs that ensure patient information is readily available at the time decisions about care are being made improve quality of care while saving time and money. Programs lacking real-time care engagement show little effect. The new era of healthcare consisting of deeper payer-provider partnerships that include care coordination, financial shared risk and even narrow networks of care offer opportunities for all involved in financing and delivering healthcare to meet the triple aim of better and more satisfying care at a lower cost. PHM offers mechanisms to turn the potential into reality.

The Industry Conundrum

Moving thousands of doctors, nurses and other healthcare professionals into coordinated, cross organization teams – a requirement for population health management to succeed – is no easy feat. Technical integrations between EHR systems never designed for interoperability are challenging and time consuming.

From a bricks and mortar hospital perspective, executives face a conundrum; “Do I focus on transforming my business to improve overall health outcomes and then secure payer contracts – or – do I focus on securing payer contracts and then transform my business to improve overall health outcomes?”

Payment Reform & Immediate Access to Community Wide Information at the Point-Of-Care: The Missing Links for PHM Success

As with any significant change, consternation and uncertainty are to be expected. But, let’s consider the flip side. This is actually the first time in healthcare history that the three key stakeholders – payers, providers and patients are aligning in support of a common goal; adopting a healthcare model that promotes disease prevention, coordinated care, quality outcomes and lower costs. We believe this alignment combined with the current technology transformation in the cloud is the breakthrough PHM needs - community wide information readily available at the point of care. Payers have the claims data. Providers have the clinical data and face-to-face patient interactions. Patients provide the missing pieces. Combining and sharing all three resources dramatically improves care and bends the cost curve.
Information Across the Community from the Payer, Linked with Providers in Front of the Patients

Doctors, nurses and therapists see patients, but often have no idea what other care is being delivered in the community. Payer information at the point of care allows a provider to immediately know the patient’s treatment history, who’s been involved in care and what interventions or testing have been done recently. Community-wide information at the point of care facilitates a dialogue about the type of care the patient has received.

For example, if a patient has had three hospitalizations at three different facilities the provider can investigate what happened during those hospitalizations and attempt to uncover the reason behind the involvement of three different facilities. Without the community-wide data from the payer, the provider would not have the information about the previous hospitalizations. The payer, on the other hand, is aware of the hospitalizations, but lacks the clinical details about the treatment and reason for visiting multiple facilities. Combining the provider and payer information, especially when the contracts and financing are aligned, allows each group to use its combined strengths and, finally, close the care coordination gap.

The Technology Transformation

The technical challenges behind the evolution of PHM models are multi-faceted. Payers historically incented providers to adopt technology and workflow based on how the payer compensated the provider. With new payment models, health insurance exchanges, plan/provider interoperability and contractual obligation to influence the medical loss ratio, change and evolution of information and communication solutions are the new norm. Both payers and providers must continue to adopt the latest innovative technologies to share real-time information and proactively collaborate with all members of the healthcare community.

Complicating the dynamic environment is the reality that providers fall across a long technological continuum that spans from paper based to highly integrated real-time structured data systems. From those at the beginning of the technology adoption spectrum to those who have implemented advanced systems, all are experiencing the challenge of determining the next “best” technology move for their organization. What system do I invest in? Do I put all of my eggs in one basket and trust one EMR to help me address this conundrum? Is an EMR even the key system I need for success moving forward? If I’m a hospital, do I keep the systems I’ve already spent millions on and wait to see if the vendors will eventually add population health management and reporting capabilities? What about Direct and other evolving communication and interoperability standards and capabilities? Are these on my vendor’s roadmap? Will I be able to pay for this investment if I enter a shared savings arrangement?

Where Technology Is Concerned, What Do Hospitals and Health Systems Really Need for Success?

According to John Stanley of Impact Advisors, a healthcare technology consulting firm, there are three core requirements provider organizations must consider as they enter the next phase of the healthcare market and technology space.

• First, operational technology is fundamental. Electronic health record systems, practice management systems, revenue cycle management systems, and all the departmental and ancillary systems run the care delivery system.

• Second, the analytic systems are emerging now as next generation decision support, business intelligence, population health management, and registry systems that can stratify and manage specific conditions for individual patients as well as across population cohorts.

• Third, are the collaboration technologies that tie the operational and analytic components together. They are health information exchanges, secure messaging programs, patient engagement systems, portals, etc. that integrate information from the providers, payers and patients.

The key to success in the next phase in healthcare lies in how organizations coordinate these three technologies to offer an effective workflow and information-sharing solution within the evolving shared-savings landscape.

The operational systems are functional at the front line, but they do not effectively manage information outside of their native environment or workflow. The collaboration technologies work with them to integrate cooperating organizations or systems that might not otherwise talk to each other.

Additionally, analytic systems aggregate information such that it can be managed across a population and not only within the walls of an entity. Now physicians, hospitals, payers, employer clinics and emerging non-traditional environments can share a common set of information to coordinate and deliver care, while managing trends and cost. As information is shared, it can be used to coordinate care delivery across a much broader population to predict risk, manage risk, and manage cost.

It is also critical to distribute the results and the inferences from the analytic systems back into the operational systems where registration clerks, physicians, nurses, care management teams, and others can use the value of the analytics. Operational system users can change the pattern of care and the trajectory of the cost model to improve the performance, using insight from the analytic system. Linking analytic insight into operational workflow has been challenging due to lack of interoperability of the operational systems.
It's About REAL Risk:

Entering into alternative payment revenue arrangements is risky business. Organizations traditionally lack the ability to predict cost and potential savings associated with unmanaged or highly coordinated care. By combining claims and clinical data with predictive technology capabilities, organizations can identify – in advance – opportunities for potentially avoidable expenses in patient populations AND drive laser focused care management activities.

By focusing on the opportunities for potential cost reduction, based on excellent care rather than just identifying the previously highest cost patients, organizations can achieve optimal deployment of care management teams.

The Ability to Collaborate Outside Organizational Walls Makes or Breaks a Population Health Initiative

With the new partnerships much of the information sharing needed to succeed in healthcare is occurring outside of the walls of the organization. With this change, the use of cloud computing in healthcare has dramatically increased becoming both a strategic and operational necessity. Another big factor in the shift toward the cloud includes the protections for providers brought about by the new HIPAA revisions. With these protections the liability for keeping patient data secure has shifted to healthcare business associates. Many organizations are in turn, shifting the contractual responsibility for securing the information to their vendors.

“We view the recent HIPAA revisions as a positive development. It significantly helps improve stakeholder trust in the cloud as a mechanism for accessing clean, portable data.”

— John Haughton MD,MS, Covisint CMIO

Cloud-Based IT Systems Reach Tipping Point

Very recently, healthcare system CIOs moved from asking “IF” they would share their information in the cloud to “WHEN AND HOW” they are going to do it. The concept of an IT silo for business advantage no longer works in the shared risk / population health future. The advantage moves from withholding to securely managing and coordinating information.

At this point, there is little dispute about the benefits of cloud computing. For example, delivering a cloud-native infrastructure versus client-server / Citrix technology allows organizations to ramp up operations more quickly, efficiently and, many times, more cost-effectively. In his book, Cloud Surfing, Thomas Koulopoulos says, “The Cloud now represents the consummate disruptor to structure; a pervasive social and economic network that will soon connect and define more of the world than any other political, social, or economic organization. The Cloud is the first megatrend of the twenty-first century, one that will shape the way we will address virtually every challenge we face for at least the next 100 years.” We believe the convergence of healthcare reform and cloud computing to be the breakthrough needed to achieve effective PHM.

TRUST is the Enabler for Outside Engagement and Collaboration

As providers evaluate and assess IT needs, it’s becoming more and more critical to gain capabilities that protect local needs, while being open to community wide collaboration. Partners and collaborators can enter into deeper relationships using flexible communication brokering technology that lives in the cloud. By doing so, they can work together yet also pull apart if competitive mergers or other arrangements quickly alter the care delivery environment.

We believe it is critical to consider solutions that promote physician and hospital administrative autonomy and organizational trust; systems that can dynamically link and unlink information sources as partnerships evolve.

Gain-sharing and care coordination between entities that may or may not fully trust each other, and who may not even have fully aligned incentives across their contracts and market, present a challenge, but “coopetition” (cooperative competition) is a necessary reality for PHM to succeed across a community. Technology exists to make coopetition a reality under the control of the technology purchaser.

There are similarities between the types of data exchange required by health information exchanges (HIEs), multi-facility integrated health systems. It makes sense to confirm capabilities, using those vendors that have the expertise and systems capable of creating and administering organization-specific configurations that easily adjust as further need arises.

Paper Isn’t a Barrier to PHM Success

A recent study of hospital C-Level administrators and clinicians conducted by Porter Research showed three-quarters of hospitals are dependent on fax communication: 74% of respondents stated they are handling their outflow of information via fax while 76% stated they are handling their inflow of information via fax. We’re a ways away from being paperless in the healthcare industry, but effective care coordination and PHM can still happen with legacy communication methods.

Full population management is easier with electronic systems, but the real key is saving time within the point of care workflow. If an initiative saves time, it sticks. An example is point-of-care shared care plan worksheets or visit planners that save about 30 seconds for each visit – when used with or without an existing EHR. Visit planners, whether on paper or accessed on a mobile device, offer community wide information that identifies patient needs and are available at the point of care. They summarize patient information without requiring a deep review of the existing electronic record notes. These shared-care plans consistently demonstrate the ability to decrease failure rates in measured outcomes by 25-50% within three to six months of implementation.
For example, a number of years ago, a small group of four doctors involved in an asthma improvement initiative used patient-level alert sheets. Even without an electronic medical record, they improved asthma controller medication use, the right medications for asthmatic patients, in six months. They improved use from 43 to 76% of their patients. This data became particularly advantageous during payer contracting - the independent practice association turned the medication improvement results into three million dollars of increased fees in a managed care contract over the following three years simply because they had data showing they were delivering excellent care. Sometimes a very small intervention measured and shared appropriately, can help to not only contain costs, but also get a larger share of value back to those who are delivering care.

Conclusion

The fundamental change in reimbursement combined with the availability of technology offers the perfect ingredients for an explosive transformation in population health management, right? Well, not so fast. We all know what sounds good on paper is often not as easy to implement.

Fundamentally, population health management is a people game. Obviously, technology is a critical piece and there are absolutely processes that need to be in place, but, ultimately, implementing successful PHM requires a coordinated effort that involves technology, people, and processes.

People vary in their level of technology adoption. We believe the key to building a technically integrated community capable of managing and tracking populations is flexibility. Leaders in PHM - whether provider or payer - need to engage their network with a comprehensive coordination roadmap and suite of capabilities that ensure all participants can exchange information from the time shared risk contracts start.

Successful PHM will require:

- Major investments over multiple years -- and will include success and failure. Flexible technology with an ability to openly integrate with other data sources is a hallmark for success. To achieve scale, convergence and consolidation must accelerate among otherwise separate organizations.
- Standardization of processes and the ability to continually improve or risk losing reimbursement.
- A strong technology foundation, including web-based reporting tools that connect to clinical, financial, and administrative systems. Systems must support analytics across a wide spectrum of inpatient, outpatient, post-acute, and community services. Information must get to the point of care when care is delivered.


In healthcare, Covisint connects over 2,000 sites, 40,000 care givers across 35,000,000 patients. Our technology has measurably improved care outcomes with small and large early adopters for more than a decade. We integrated a group of three recognized market-leading technologies with the proven Covisint core platform to create the most integrated Accountable Care solution in healthcare. We have the proven expertise to connect disparate care teams, deliver sophisticated solutions at the point of care, and quickly demonstrate significant cost reductions.

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