Three Key Elements for Successful Population Health Management
QUESTIONS FOR HEALTH SYSTEM LEADERS

What businesses should you be in? Who will your partners be? What is your role in the communities you serve?
Environmental forces are combining to cause major changes to our industry. The Baby Boomers have started enrolling in Medicare. Information and data are increasingly available—and portable. Chronic disease incidence is reaching epidemic proportions. And health reform has set a new timeline for change.

Together, these forces are pushing providers past the point of incremental change toward a new business model centered on delivery of comprehensive care and management of total cost risk. Organizations on the transition path to population health management must prioritize three foundational elements:

1. Information-powered clinical decision-making
2. Primary care-led clinical workforce
3. Patient engagement and community integration

Read on to learn about strategies progressive organizations are pursuing in each of these areas.
Information-powered clinical decision-making

- Use robust patient data sets to support proactive, comprehensive care
- Operate within an integrated data network
- Position a leader to merge data analytics with clinical care

Primary care-led clinical workforce

- Elevate PCP to “CEO” of care team
- Mobilize community workforce to extend care team reach

Patient engagement and community integration

- Map services to population need
- Overcome non-clinical barriers to maximize health outcomes
- Integrate patient’s values into the care plan
- Use community stakeholders to connect patients with high-value resources
ONE

Information-powered clinical decision-making

Population health leaders need to focus on the data and information that will increasingly power clinical decisions.

Today, the health care industry is building toward a vision of complete data integration, getting the right systems in place to work with each other. While this is no small feat in itself, the next challenge will be leveraging data to redesign care. Health systems will need to be able to use IT systems to advance clinical outcomes, improve quality, and lower costs.

Ultimately, to achieve competitive advantage in your IT investments, you must be able to use the wealth of information at your disposal to deliver information-powered care to patients in real time.
Use robust patient data sets to support proactive, comprehensive care

If you’re going to deliver information-powered care, you’re going to need more regular access to information about patients’ health status. How do you get more information from patients about what they’re doing when they’re outside the four walls of the doctor’s office?

Henry Ford Health System connects data from annual Health Risk Assessments with annual primary care visits to develop personalized care plans.

Beneficiaries who complete this process are enrolled in an expanded insurance plan, where a family of four can save over $1,000 in out-of-pocket health care expenses each year.¹

Connecting employees to their PCPs, getting an accurate assessment of health status, and intervening before problems ensue is already cutting costs.

And the more you know about an individual, the more you can create unique care plans to meet the patient’s needs. The P4 Medicine Institute is a collaboration between Ohio State University and the Institute for Systems Biology to track extensive sets of data related to patients’ total health. Each patient receives a customized diagnostic profile, including a physical exam and detailed biomarker analysis, which is the basis for an individual care plan. The plan is reinforced by real-time, ongoing biological screening and self-management support.

The disease-risk analysis may predict future issues, allowing physicians to engage patients in behavioral modifications and interventions to slow or even prevent the onset of diseases.

¹ $470 in out-of-pocket expenses on expanded insurance plan; $1,480 in out-of-pocket expenses on the standard plan.
P4 is mostly an aspiration today, but hospitals have come a long way in their ability to use data to direct care. We’ll continue to move forward on two fronts:

1. From thinking in terms of managing a population to using personalized information to create individually customized care plans

2. From retrospective analysis to acting in real time to prevent adverse events

Ongoing access to and analysis of patient health information is the key to providing proactive, preventive care.
Operate within an integrated data network

To leverage data, you’ll need an integrated network to allow information sharing across platforms within your organization’s walls and across independent providers. Meaningful use has already started to reshape the IT investment landscape, and there were over 250 operational health information exchanges in 2012.

Advances like HIEs also signal the decline of data ownership as a differentiator among providers.

As data access becomes universal, organizations will set themselves apart by what they do with that data.

Position a leader to merge data analytics with clinical care

While CIOs continue to focus on building, refining, and maintaining the IT backbone, other leaders will need to figure out how to mine information from clinical and operational data, distill best practices, and create information-driven care plans.

North Shore-Long Island Jewish Health System filled this need by creating the Chair of Population Health. Her team tracks the impact and results of pilot programs, determining which have the greatest measurable impact and thus should be offered to local businesses and the community at large.

Every organization will need to differentiate its clinical services by leveraging and applying data analytics—and find someone with the appropriate knowledge and credibility to lead the effort.
TWO

Primary care-led clinical workforce

Advances in information-driven care will have a profound impact on the clinical workforce. In a data-powered world, the critical skills of the workforce are those that connect most directly to the “laying on of hands” and motivating patients to achieve better outcomes.

Next-generation technology will support providers in advancing clinical care to help establish high-quality, low-cost care pathways. Technology will also allow providers to extend the reach of the workforce. And within care management, technology will play a supporting role as PCPs manage larger clinical teams and patient panels to help improve overall population health.
Elevate PCP to “CEO” of care team

When it comes to primary care, the critical issue for the future is shortage—we’re going to be short tens of thousands of PCPs by the end of this decade.

And we’re unlikely to fill the primary care gap with physicians alone. Instead, hospitals and health systems will need to build comprehensive primary care teams, with the PCP working as the quarterback to manage care across a range of providers including advanced practitioners, nurses, social workers, and other providers.

Prioritize Top-of-License Practice from Entire Team

“CEO” of Care Team
- Team and operational manager, leadership decisions enable top-of-license practice
- Service oriented, strong interpersonal skills
- Financial, performance, and clinical information manager
- Traditional business competencies such as leadership, strategy, delegation are key

Care Managers
- Effective communication skills crucial
- Team work ethic enables top-of-license practice
- Strong critical thinking competencies
- Longitudinal and proactive patient care focus
- Able to coordinate, manage non-clinical personnel
With this training and new team structure, how big could a PCP’s panel get? You can’t push panel size too quickly—PCPs must first get comfortable with new competencies like team-based care and integrated technology—but you will need to accommodate more primary care demand. Additionally, managing the transition requires removing barriers in current incentives to encourage physician support of team-based care and panel expansion.

**Dean Health System** has been actively converting primary care practices into medical homes since 2004, equipping primary care sites with teams of clinicians working at the top of their licenses. Technology provides additional access and support to patients outside of the practice walls.

And Dean aligns the compensation model to the goals of the medical home. This ensures physicians are rewarded for meeting the care management needs of patients.

**Productivity Measures on the Way Out, Quality Measures On the Way In**

PCPs will need to be comfortable managing a team of clinicians, which means they will need training in team management. Incentives should be aligned to population health management goals.

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1 Total greater than 100%.
2 Percent patients active on the MyChart patient portal.
Mobilize community workforce to extend care team reach

The care team model likely also includes some new members—specifically non-clinical workers who can help patients navigate the health care system and peers who can provide ongoing coaching and support.

At Carondelet Health Network, a community health worker on the diabetes care team helps with basic tasks such as maintaining the registry or calling patients to remind them about upcoming appointments. They also help bridge language and cultural gaps between the patient and the care team.

WellMed Medical Group has broadened its non-clinical workforce to include patient peers. Physicians select high-performing, well-managed diabetics who they think would be good mentors; the mentors participate in a four-day, 16-hour training course and then are matched with mentees identified by their doctors as needing additional self-management support.

The program not only drove improvements in mentees’ health status—mentors benefited, as well.

To improve patient activation, put someone on the team—potentially a non-clinical peer—whom the patient can call with questions or for additional guidance and support.
THREE

Patient engagement and community integration

The first two elements focus on competencies the health system needs to develop. The third element shifts the focus outward: how you relate to patients and ultimately your community. What place do you want to occupy in the health care ecosystem? If health care is to become patient-centric, where do you need to be?

The challenge of becoming a patient-centered enterprise is that people do not want to be patients; providers are outside of the sphere of their day-to-day activities. If you are going to partner with patients in managing their health—and especially if you are going to be at financial risk for the health of those patients—you must integrate into patients’ daily lives.

**How far can, and should, the health system reach?**
You’ll need to overcome non-clinical barriers to achieve the best outcomes, integrate patients’ values into the care plan, and communicate continuously with patients to address and bridge care gaps. Finally, you’ll need to integrate community stakeholders who can connect patients with high-value resources, while expanding your reach beyond the clinical care continuum to anchor community health.
Population managers must build connections across the entire care continuum. In Schenectady, N.Y., a health system has become an exemplar of matching service offerings to community need.

The New York State Legislature created the Berger Commission to address statewide cost and utilization issues. The commission analyzed markets and determined that in Schenectady, a tertiary care hospital, a women’s hospital, and a hospital treating many of the city’s underprivileged residents should be merged into a single community provider.

The leadership team used this mandate as a call to reevaluate community needs and match service offerings to those needs. Today, Ellis Medicine has an acute care hospital, with the two remaining facilities reenvisioned as a women’s center and a comprehensive medical home.

The Ellis Medicine Medical Home provides not only outpatient medical services and robust primary care but also dental care. Social and community services are integrated as well, creating a one-stop experience for all of the patient’s health-related needs. For example, when community members come to the Ellis Medicine Medical Home, they also find a welcome center for the school district.

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1 Pre-admission testing.
At the start of this transformation, Ellis’ CEO reached out to other community organizations delivering health or social services to truly build a seamless continuum of patient-centered care. Twenty-five community leaders meet quarterly to improve collaboration and reduce duplication among community offerings.

The results: Visits to the medical home are rising quickly, while ED visits at Ellis’ hospital remain stable.

![Number of Visits to Family Health Center, Emergency Department]

Strengthening options across the continuum of care can simultaneously improve utilization patterns and better serve the community.
Overcome non-clinical barriers to maximize health outcomes

We know that a small minority of patients drive a disproportionate share of health care spending. For many of these patients, the greatest barrier to improving their health is not a clinical issue but a social or financial barrier.

Massachusetts General Hospital joined the CMS Medicare Care Management for High-Cost Beneficiaries Demonstration to address the needs of their 2,500 highest-risk, costliest Medicare patients. The hospital assigned each patient to a comprehensive care team, which included a primary care physician, an experienced nurse case manager, a social worker, and a pharmacist.

They also hired a non-clinical community resource specialist to work with the care teams, focusing on the non-clinical factors that influence clinical outcomes. If transportation problems prevent a patient from getting to appointments or filling prescriptions, the community resource specialist—who builds and maintains a database of community resources—connects the patient to transportation resources. This approach allows clinical team members to operate at the top of their clinical licenses without having important non-clinical needs slip through the cracks.

This intensive care management model has driven major improvements in outcomes and produced significant ROI: ED visits, hospitalizations, and mortality rate have all declined, and the program saved $2.65 for every dollar spent.
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Acknowledging and addressing non-clinical challenges outside of the normal primary care structure improves clinical outcomes, especially for the highest-risk patients.

1 Part of management team that includes Project Manager and Team Leader for Case Management.
Integrate patient’s values into the care plan

You must also consider your relationship with patients when they are faced with difficult, complex medical decision-making. At no time is this more critical than when considering end-of-life care.

Sutter Care at Home’s Advanced Illness Management (AIM) program provides both curative and comfort care within a patient’s home, then transitions patients to hospice as needed or desired.

The AIM care team comprises nurses and social workers, who manage the home care, and a physician, who acts as a consultant. The physician creates the care plan with extensive input from the patient and family. The care plan is structured around meeting patient goals. “We believe in person-centered goals,” Sutter Care at Home’s CMO notes. “People want to be people, not be patients. A personal goal might be to sit at the dinner table every night with family. Clinical goals should emerge from and support these personal goals.”

The results are striking: Acute care hospitalizations are way down, and hospice use is way up, leading to a $2,000 decrease in per-patient monthly costs for those enrolled in the program. Patient and family satisfaction rates are up, as well—proof that you can find real return in doing what is right for each patient.

Incorporating patient input and goals can improve care planning—and outcomes.
Use community stakeholders to connect patients with high-value resources

To truly improve the health of the community, you need to think beyond the patients who are in your offices and hospitals today. You need to find those who are at risk and bring them into the system so that you can begin to manage their underlying problems before they become acute. To do this, you will need to integrate more deeply into communities and partner with those who have influence within them.

In Chicago, a multi-stakeholder task force—including Rush University Medical Center, Sinai Urban Health Institute, and multiple community groups—developed a plan to address diabetes in the 72-block Humboldt Park neighborhood, where incidence of the disease is double the national average.

To identify residents at risk for diabetes, respected community members go door-to-door to conduct risk assessments, inform residents of their diabetes status and risk, connect those without a primary doctor to a local health care provider, and discuss healthy behaviors. A neighborhood Diabetes Empowerment Center reinforces the goals of the program, offering aerobics classes, a kitchen for healthy cooking demonstrations, nutritionist services, and more traditional diabetes education.

More than 1,000 patients have been connected to primary care providers.

It’s not enough to treat the patients already in the system; to make a meaningful impact on community health, providers need to reach at-risk residents.
CONCLUSION

Future success will require a different playbook than the one health systems are operating with today.
Are today’s measures of success the same ones that will indicate strength in the future? You must think about building the assets, relationships, and skills that your system will need to thrive in a new environment.

Not every organization is on the same transition path; each serves its own population and patient needs. We’ll likely see many different roads forward—the challenge is figuring out which one is the right path for your organization, the direction that best aligns organizational strengths with the needs of the community.

Amid this change, health systems must maintain the heart of the business—high-quality patient care. No other institution is more integrated into the community or holds more responsibility for the health of those living in it. Improving health is at the core of the mission—and if you successfully build the population health management enterprise, you’ll continue to advance the value you provide to those patients who rely on you every day.
About the Care Transformation Center
This piece is based on a larger research initiative on care transformation. We provide expert guidance to our members as they transform into large, integrated systems responsible for managing patients' health across the entire care continuum.

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Link to more resources on the Mass General case study: