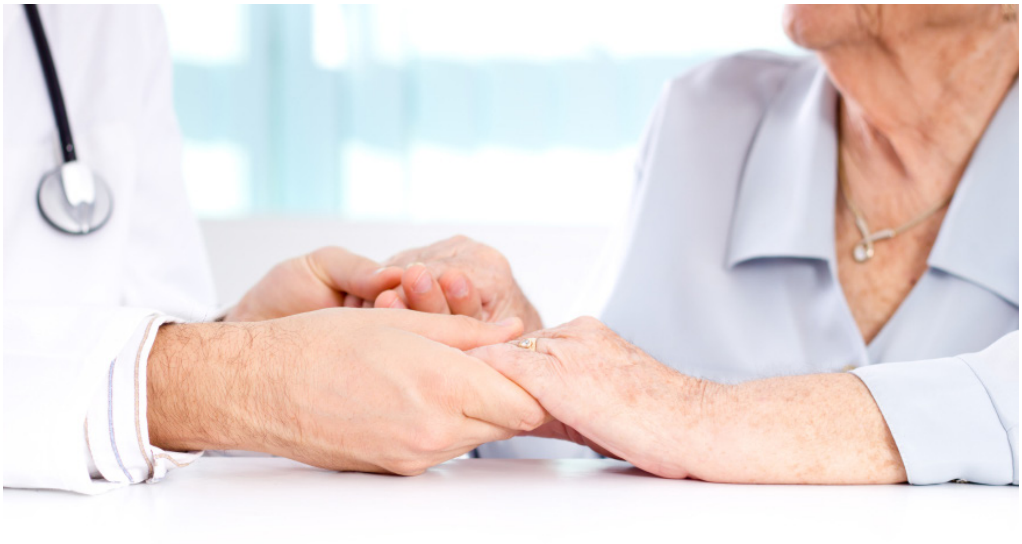
FierceHealthPayer

A *FierceHealthPayer* eBrief

Sponsored by:

LexisNexis®

MOVE BEYOND DELIVERY SYSTEMS TO IMPROVE POPULATION HEALTH



Population health improvement is not "just a healthcare thing," according to Loel Solomon, Ph.D., vice president of community health at Kaiser Permanente, based in Oakland, Calif.

It requires healthcare organizations look at health drivers that exist outside of the delivery system, he says. Collaboration among healthcare organizations, as well as with public health agencies, social service agencies, schools and other community organizations, is key to improving outcomes and understanding patients in a healthcare environment of shared responsibility.

"We're involved in a lot of community collaborations that include payers, providers [and] public health departments. We're trying to put the population in population health," Solomon says.

As an integrated delivery system comprised of Kaiser Foundation Hospitals and their subsidiaries, Kaiser Foundation Health Plan and The Permanente Medical Groups, the organization has internalized economic incentives to improve population heath. The connection between member premiums and the delivery system has given Kaiser the right incentives to invest in upstream public health initiatives that keep people healthy.

While new payment and delivery models, including accountable care organizations (ACO) and patient-centered-medical homes (PCMH), strengthen incentives to improve care quality at the population level, Solomon points to a solution found outside the boundaries of healthcare delivery: community change.

COMMUNITY PARTNERSHIPS

Most patients only spend a few hours a year in Kaiser's medical office buildings, Solomon explains. They spend more time in the care of the community. So healthcare organizations must connect in a systematic way with community-based organizations and create conditions of health around all the settings where people spend most of their day, he says.

Kaiser Permanente has done just that for the past eight or nine years. The integrated delivery system has been working in about 40 communities, promoting population health initiatives such as healthy eating and active living. "The partners vary and the strategies vary, depending on the needs of the communities, but they almost always include schools, public health and community groups," Solomon says.

Cooley Dickinson Health Care in Northampton, Mass., has also centered its population health improvement efforts on community partnerships. The Massachusetts General Hospital affiliate spent most of 2013 conducting surveys, holding focus groups and running community forums to gather input from community leaders and narrow its population health focus, says Jeff Harness, M.D., director of integrated care and population health at the 140-bed hospital.

"We're looking at ways we can partner with community agencies and local municipalities to improve the so-called environmental conditions—the social, legal, cultural and media conditions that we're all part of—through policy changes, advocacy, funding programs and redesigning physical spaces," he explains.

"We're involved in a lot of community collaborations that include payers, providers, public health departments. We are trying to put the population in population health"

Loel Solomon, Ph.D., vice president of community health, Kaiser Permanente, Oakland, Calif.

INFRASTRUCTURE AND INSTITUTIONAL CHANGE

As healthcare organizations work to identify at-risk populations and effectively manage them, they'll need to make necessary infrastructure changes.

At Cooley Dickinson, that involved adding social workers to the mix to give patients an extra layer of support beyond what primary care physicians can do, Harness says. His hospital also formed physician panels to better look at entire populations and their needs.

Population health improvement efforts also created a need for data and high-risk patient prediction, Harness says, adding that the ability to rely on shared data to determine which patients are most at risk requires getting all parties on the same electronic medical record system.

"The need for data has never been so great. The need to predict high-risk patients has never been so great. And the need to access data in as close to real time as possible has become more and more important," he says.

In addition to the right health IT tools, healthcare organizations must implement a care coordination infrastructure—such as adding more registered nurses to the staff—and a physician communication strategy that gets everyone on the same page about new payment models, goals and provider accountability, says Dave Chokshi, M.D., director of population health improvement and assistant professor of medicine and population health at the 1,069-bed New York University Langone Medical Center.

CONTINUED ON PAGE 4...

GAME CHANGERS

Leveraging data and analytics to help providers manage risk

Forces have converged to compel providers to make sweeping changes in the way they deliver health care, as well as the way they conduct their business. A concern for many is clinical and financial risk management, a concept at the core of new models and payment trends.

Caught in the middle, providers are being asked to shoulder more of the financial risk traditionally held by insurers while stimulating patient accountability with a focus on at-risk patients –with the goals of improving care and reducing costs.

While providers may consider risk management a discipline outside their range of understanding, they should understand this: The right technology and analytics can convert a seemingly overwhelming task into a powerful operational and competitive advantage.

"Analytics will not only guide plans based on motivation, they will expose underlying risks that are not apparent through other means."

Meaningful Data for Appropriate Action

The best path for payer-provider collaboration is through analytics, which can integrate clinical and administrative data, uncover risks that are not generally obvious, identify gaps in optimal care and predict future costs. With greater transparency and sharing of data, both payers and providers can navigate their way through accountability, risk-sharing, and collaborative care, and react with more agility as payment reform evolves.

When aggregated claims and clinical and public records data are combined with predictive analytics, providers and payers alike can benefit from the same, clear view of the populations they are managing, as well as the insights needed to prioritize care and engage and educate individual patients. As analytics evolve to have socioeconomic data influence the motivation analyses of patients, providers and the care team have a clearer path to assigning the appropriate level of resources, which enable a "tiered" approach to care.

Analytics will not only guide plans based on motivation, they will expose underlying risks that are not apparent through other means. Likewise, measuring how motivated a patient is to self-manage their condition leads to being more successful in patient engagement, critical to success in value-based programs.

Quality-focused tools enable providers to identify care that has not met the standards of clinical protocols, and patients who have not been compliant. The ability to compare outcomes for different patients with the same types of risks is another value to analytic driven care. Insights on care delivery and approaches can be fairly managed to award incentives or shared savings, as well as to provide a feedback loop to the providers for their ongoing improvements to care. A robust tracking capability provides metrics for demonstrable improvement and success.

Conclusion

Predictive analytics become more appropriate with additional inputs available in public records. Advanced abilities to evaluate provider performance enables quicker and more accurate feedback on the care provided. Risk is lessened as sound decisions replace educated guesses for patient care, operations, discharge planning and other scenarios.

The resulting stronger collaboration leads to lower costs, improved outcomes and better patient engagement, thus enabling Triple Aim and other health reform initiatives to be successful.

After all, it's one thing to see into the future; it's another to do something to improve it.

LexisNexis®

...CONTINUED FROM PAGE 2

PAYER INVOLVEMENT

Health insurers play an indispensable role in population health improvement, according to Chokshi. "The way that payment is structured is fundamentally important to how care delivery will be restructured," he explains.

Moreover, through population health payment models with health insurers, providers can assume added risk. That's why leadership at NYU Langone Medical Center has a vision for how commercial shared savings arrangements, ACOs and bundled payment contracts can enhance integration and care coordination, Chokshi notes.

"The need for data has never been so great. The need to predict high-risk patients has never been so great."

Jeff Harness, M.D., director of integrated care and population health, Cooley Dickinson, Northampton, Mass.

Similarly, Cooley Dickinson Health Care has worked together with commercial payers to decide the measures, outcomes and reimbursement rates within its at-risk contracts. "I certainly could envision working with the health plans in the future to think more broadly about health and perhaps involve the payers more directly in community efforts," Harness says.

Choskhi points to the success of New York's Montefiore Medical Center, which has an integrated payer organization, at improving population health. Under the rubric of an ACO, Montefiore can align the payment incentives from the payer side with care the coordination infrastructure operating within the healthcare system.

PROMISING RESULTS

Kaiser Permanente's focus on schools has shown the most promising results around population health improvement. There have been real improvements in diet and physical activity
behavior change at the population and neighborhood levels, particularly among children, says Solomon.

To gauge population health, Kaiser looks at school cafeteria menus, the number of bikes lanes in the community, park space dedicated to physical activity and county and city plans that contain health limits.

However, Solomon notes population health changes take a long time to develop and don't show up in health metrics for a number of years. Most involve infrastructure changes, but the health impacts are huge and produce significant long-term benefits in the community.

"It's one of the things that people who talk about population health miss. A lot of population health … is really focused on a small number of people who already have disease—we're trying to get out in front of that at-scale," he says.