HOW TO UNDERSTAND, ENGAGE AND MEASURE WITH POPULATION HEALTH

In most medical practices these days, the standard method of operation is to look at each patient as an individual with separately identifiable needs. The provider reviews the chart before the appointment, discusses current health issues with the patient, provides lifestyle education and prescriptions as needed, and annotates the chart properly. The chart is then either closed on the digital platform or returned to the file room, and is usually not referred to again until the next appointment, or the patient calls the practice for some reason.

> "Some observers see population health as a new term that highlights the influential role of social and economic forces in combination with biological and environmental factors, that shape the health of entire populations."
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> —American Journal of Public Health

Little thought is given to the practice's population as a whole. The provider may intuitively feel that there are a lot of patients with diabetes, or it might seem like patients are just not engaging enough in their own healthcare. Little attention is really paid to the matter, however, as the provider has to move on to the next appointment or deal with a claims payer on an insurance matter.

But what would happen if the provider had a tool that would help to look at the entire population health, and take appropriate actions, in addition to providing critical in-person care during the face-to-face appointment? Well, not only is this now a possibility with the ongoing transition to EHR (Electronic Health Records), it is also becoming more of a necessity to fill patient care gaps and meet Medicare reimbursement requirements.

Population health is an approach described by David Kindig, MD and Greg Stoddart, PhD, as "the health outcome of a group of individuals, including the distribution of such outcomes within the group." It is an approach that aims to improve the health of an entire patient population on an overall basis, in addition to working with the patients one-on-one to address individual health issues. Tools are now available which can assist the provider in easily reviewing the data, spotting health issue trends, and taking action to improve patient compliance with care activities.

Some providers may wonder whether these activities can be handled through the EMR they currently have in place, but it takes much more than just a basic cursory understanding of an individual patient's health history to understand, engage, measure and truly improve entire patient population health care and risk stratification demands. While the EMR is great at analyzing a single patient, a population health tool aggregates data so that the provider can look at the practice as a whole. Practices benefit by enhancing the effectiveness of care provided, while also improving their financial performance – in essence, population health is a win-win for the practice and the patients.

A population health tool enables the practice to identify care gap trends based on care plans, identify individual patients with care gaps and those not meeting quality metrics, and proactively engage patients through automated notification tools. These remind the patient to take specific actions such as vaccinations or blood tests, or to call and schedule a needed appointment, which ultimately fills in empty appointment slots on the schedule and keeps the practice running at full capacity.

The framework that provided the push for the term "population health" is the Triple Aim of Healthcare:

- Improving the individual experience of care
- Reducing per capita cost of care
- Improving the health of populations

WHAT IS POPULATION HEALTH AND WHY DOES IT MATTER?

Population health utilizes tools that aggregate data from an EHR or EMR to aggregate, analyze, and achieve total practice results, such as better patient care and decreased costs. This is especially important in view of the evolving healthcare landscape, which is transitioning from a pay-for-service platform to a value-based reimbursement system.

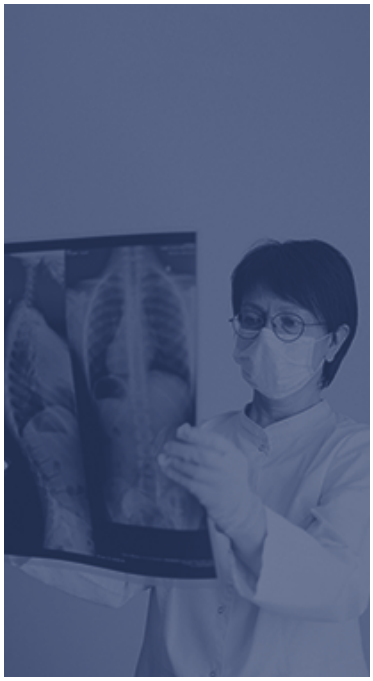
While providers may be experts at analyzing patients as individuals, they need a platform which enables them to leverage electronic medical systems to help in analysis and provide better clinical outcomes for their entire group of individuals. The Milken Institute School of Public Health describes population health as “an opportunity for health care systems, agencies and organizations to work together in order to improve the health outcomes of the communities they serve.” It centers on doctors, care providers and medical practices that are providing the very best healthcare outcomes to the entire community they serve by taking the additional step of looking at the practice as a group.

This approach must be incorporated into daily practice routines because industry reimbursement systems are gravitating toward and aligning with population health metrics. The Merit-Based Incentive Payment System, or MIPS, incentivizes practices to recognize and close care gaps, and provides reimbursement for up to 20 minutes per month for any healthcare provider to engage in chronic care management with high risk patients. Other payers are starting to adopt this approach as well.

A population health tool works by enabling the provider to understand, engage and measure overall patient health. The tool does the work of analyzing the data in individual records and alerting the provider of required actions. The tool may show that the practice has a high percentage of diabetic patients who have not had a recent blood test performed, or that a percentage of the two year old population is in need of specific vaccinations. The provider can then formulate a message to be sent via voice mail or text to the affected patients, thereby eliminating the need for time-consuming follow-up calls and reminders.

Providers are no longer limited to just patients who come to the office with issues. They can now obtain a bird’s eye view of the entire patient group to ensure those with the highest risk receive the necessary care

WHAT TO LOOK FOR IN A POPULATION HEALTH MANAGEMENT TOOL



A population health management tool should be able to easily crawl through extensive amounts of patient data in the EHR or EMR and highlight the higher risk and chronic patients for the provider to address. This ensures that patients who need the most attention receive it first. The question of how to identify patients who need care can usually be answered by following the Clinical Quality Measures, or CQMs, as defined by CMS.

The provider should be able to get an at-a-glance overview through the tool dashboard, and then be able to drill down to address practice goals. For example, the provider may set up the dashboard to focus on care gaps with respect to diabetes, hypertension, depression or COPD CQMs, and to focus specifically on those patients who have not recently been to the office for follow-up care. Or the provider may choose to focus on time since last appointment.

The tool should also facilitate patient engagement in regard to highlighted trends. Each practice may have different health management needs, but some of the most essential components to look for in a population health management tool include:

Care Gap Analysis

The care gap analysis feature looks for patients who qualify for a given CQM such as childhood vaccinations, and highlights those who have a care gap. It can be used to identify patients to address with preventative and critical care needs. It should also look for patients with a certain number of chronic conditions to enroll them for the Chronic Care Management program, or for patients who have had a certain amount of time elapse since their last appointment. For example, care strategies might include guidelines for diabetes patients to ensure they have an eye exam, foot exam, and hemoglobin control measurement.

Clinical Quality Measure Tracking

If CQMs are a practice focus, the provider wants to be able to check compliance with those measures and ensure patients are complying with enough measures to secure incentive payments for the practice.

Patient Engagement

Finally, it does no good to highlight patients in need of care if there is no way to motivate them to take action. The problem, however, comes in if this task requires a substantial amount of provider or administrative staff time. Instead of individual manual calls to each patient, the tool should be able to perform a mass outreach by sending an automated telephone call or text message to the designated patients reminding them to take and action or come in for an appointment.

Chronic Care Management

Under the Medicare guidelines, any patient with two or more chronic conditions that are expected to last for twelve months or longer is eligible for billing of chronic care management every month. They cannot be enrolled with any other practice as a CCM patient. The tool should highlight high-risk patients who may be eligible for CCM. Once enrolled it can pull up a monthly list for non-face-to-face care via phone or the patient portal, where a provider can walk patients through points based on their individual care plan. This results in a higher level of care for each patient.

THE BENEFITS OF POPULATION HEALTH MANAGEMENT

It is not just hospitals or large practices that can benefit from proactive care management; smaller practices and individual providers can realize significant benefits as well. Although the main benefit of population health management is certain to be better patient care outcomes through improved patient care and compliance to guidelines for specific diseases, there are also specific benefits to the practice as well, including:

- Placing a focus on high-risk patients most in need of care.
- Increased practice productivity by eliminating cumbersome notification tasks for routine care notifications.
- Increased patient compliance with CQMs.
- More appointment slots filled on a regular basis, so the office is functioning at full capacity.
- Additional revenue is generated by scheduling routine appointments that may have been overlooked, instead of waiting for the patient to come in with some type of emergent health issue.
- Higher revenue by securing Medicare incentives and reimbursements.
- Automatic billing for Chronic Care Management makes sure the practice is reasonably compensated for its time investment in patient care.
- Patient Engagement Metrics can be generated to reveal appointments made and revenue generated by outreach campaigns.
- To obtain maximum benefits, find a population health tool that has the modules your practice needs to thrive.