Population Health Management: Proven Model Drives New Solutions

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Research dating back to the 1970s has verified the dominant influence of social, economic, and environmental determinates in the maintenance of health and well-being. Working from a set of values that focus on overall health, quality of life, and well-being, population health management endeavors to make possible individual and community empowerment of healthcare consumer populations, realizing an expanded sense of control over the many complex factors that affect health.

In recent years society has come to embrace a new awareness that lifestyle actions, such as lack of daily exercise and poor health habits, are not merely a matter of individual choice, but are influenced and driven by a myriad of social, economic, and cultural dynamics intrinsic to one's work, family, and social environments.[1]

Moreover, it is not surprising to learn that research confirms that eliminating hazards and reducing environmental risks will greatly benefit one's health and will contribute to attaining public health goals.[2] Population health management has emerged as the best practice approach to integrate the broader evidence-based determinants of healthwith the activities of health promotion.

In recent years, population health management has benefited from an increasing audience of proponents interested in improving overall quality metrics by focusing on healthcare value—not volume.[3] The shift to value-based programs is the most significant paradigm shift in healthcare delivery since the introduction of diagnostic related groups (DRGs). Focusing on value-based care will reward healthcare providers with incentive payments for the quality of care they deliver. The impact of these programs will be game changing, as compliance will move healthcare toward paying providers based on the quality rather than the quantity of care they give patients. These programs are part of a larger quality strategy to reform how healthcare is delivered and paid for. Value-based programs also support the Centers for Medicare and Medicaid Services' Triple Aim of healthcare:

1. Better care for individuals
2. Better health for populations
3. Lower cost[4]

Population Health Drives Value-based Reimbursement

In January 2015, the Department of Health and Human Services (HHS) announced new value-based payment goals tied to advanced alternative payment models (APMs) in Medicare. Beginning at the end of 2016 the Medicare Access and CHIP Reauthorization Act (MACRA)—bipartisan legislation signed into law on April 16, 2015—will drive the creation of new APMs that will establish a fixed target price for each episode of care. Entities that deliver higher-quality care will be reimbursed at a higher target amount.

A new Merit-based Incentive Payment System (MIPS) will serve to link fee-for-service payments to quality and value. These programs are part of a larger quality strategy to reform how healthcare is delivered and paid for.

The MACRA goal is to drive the transformation of our healthcare system by focusing efforts on three areas: incentives, improved care delivery, and information sharing. Specifically, MACRA will introduce the following changes:

- Repeal the sustainable growth rate (SGR) formula
- Change the way that Medicare rewards clinicians for value over volume
- Streamline multiple quality programs under MIPS

- Provide bonus payments for participation in eligible APMs

Through MACRA, HHS seeks to:

- Offer multiple pathways with varying levels of provider risk and reward ratio that tie more of their reimbursement to value
- Enable a gradual expansion of opportunities to incentivize a broader range of providers to participate in APMs
- Implement administrative changes designed to minimize and control additional reporting burdens on physician participants in APMs
- Improve communications designed to promote understanding of physician or practitioner status with respect to MIPS and/or APMs
- Enhance support for multi-payer initiatives and the development of APMs in Medicaid, Medicare Advantage, and other payer arrangements[5]

Based on the growing number of value-based reimbursement initiatives, the Institute of Medicine (IoM) is increasingly calling for the incorporation of population health management to leverage healthcare delivery.[6] The IoM cited the work being done at Duke University's Department of Community and Family Medicine to develop a set of competencies and best practices for population health management.[7] The resulting competency map provides a framework to guide development, implementation, and assessment of population health program initiatives to strengthen the link between providers and public health. Key to the success of this collaboration is the creation of a common shared focus and language that calls for clinicians to increase efforts to align and standardize the collection, analysis, and exchange of data with public health stakeholders.

Value-based reimbursement will make management of populations a necessity as pay for performance, accountable care organizations (ACOs), and patient-centered medical homes emerge as prominent parts of the health system landscape. Under the value-based model, clinicians will be required to demonstrate practice-based improvement through an analysis of patient panels and the populations they serve. To ensure success, healthcare providers will need to employ community engagement strategies, such as aligning with public health departments, community organizations, and agencies to understand and address local population health needs.

Population health management leaders will need to develop a new skill set focused on program, workforce, and fiscal management; cross-professional and domain teamwork; problem resolution; exchange of ideas; consensus building; data analysis; and critical thinking to successfully navigate a new and complex healthcare environment.

Establishing Population Health Management Programs in Healthcare Organizations

Keys to the establishment of successful population health programs in healthcare organizations are:

1. Employing public health methods of prevention and collaboration with public health departments
2. Engaging with disparate partners from across the community
3. Embracing analytical, data-driven critical thinking and assessment skills
4. Learning to work on interprofessional teams[8]

Population health management emphasizes the essential role that non-clinical dynamics play in health outcomes. Increasingly, clinical providers are assuming financial responsibility for their entire community population, not just the population that they serve. This expanding scope incentivizes providers to discover ways to influence health through the myriad of factors that influence the greater populations' health and well-being.[9] Committing one's organization to population health management demands a redefined mission and vision focused on the analysis of cost and value and not just the organization's financial bottom line.

As a result, the most important organizing concept at all levels becomes understanding, living, and balancing the goals of the Triple Aim. The Institute of Medicine has chartered a "Roundtable on Population Health Improvement," bringing together diverse experts from academia, urban design, medicine, public health, social sciences, and other fields to collaborate and design a population health plan of action.[10]

The roundtable agenda includes advancing consensus-based recommendations on expanding reimbursement models to include population health involvement, and realigning traditional clinical medicine and public health relationships to benefit population health outcomes. Healthcare providers should not expect to influence population health initiatives and metrics by remaining in their clinics or talking one-on-one with individual patients in their communities as they have done in the past.[11]

Population Health Management, Systems Interoperability, and Standards

Information sharing is key to the success of population health management. Comparing data from different communities, providers, and patients is a driving need and force for information systems interoperability (i.e., the ability to share data). Standards are essential for information systems interoperability.[12]

Specific examples of standards for information sharing between healthcare organizations and public health agencies were discussed at the 2016 AHIMA Convention session entitled "Connecting Healthcare to Public Health and Big Data." Speakers from the Centers for Disease Control and Prevention, New York Presbyterian Hospital, and a Big Data company discussed their efforts working with standards development organizations, such as Health Level Seven (HL7) and Integrating the Healthcare Enterprise (IHE), to guide the development of interoperable standards-based health information technology solutions for population health data sharing.

The Public Health Data Standards Council (PHDSC), which includes representatives from federal and state public health agencies as well as public and private organizations, has been guiding the AHIMA activities on standardization of clinical, public health, and population health information. To join AHIMA-PHDSC, please contact Diana Warner at diana.warner@ahima.org.

Notes

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[4] Centers for Medicare and Medicaid Services. "CMS Value Based Programs."

[5] Centers for Medicare and Medicaid Services. "MACRA: Delivery System Reform, Medicare Payment Reform." 2016.

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[8] Ibid.

[9] May, Ellen. "Population Health Management: Defining the Provider's Role." *Healthcare Executive* 28, no. 4 (November 2013).

[10] Institute of Medicine. "Roundtable on Population Health Improvement." National Academies of Sciences. (2016).

[11] May, Ellen. "Population Health Management: Defining the Provider's Role."

[12] AHIMA. "Standardizing Data and HIM Practices for Interoperability." *Journal of AHIMA* 87, no. 11 (November 2016).

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