OPTUM™

Managing populations to improve individual care

Best practices for physician-based population health management

Accountable care and the move to fee-for-value have captured the attention of payer, hospital and physician executives across the country. More organizations are starting accountable care organizations (ACOs) and entering into other risk-sharing arrangements that incentivize fee-for-value rather than fee-for-service with the goal of increasing revenues and profit margins. As physicians and hospitals prepare to take on risk, it will be essential for providers to take ownership of the population health management role traditionally led by payers.

Managing financial risk is a foreign concept for most providers. They're used to getting paid because they provide care, not because they meet certain quality or performance measures. Yet times are changing. Fee-for-service reimbursements are shrinking, and payers are incentivizing providers for quality and care management while penalizing mistakes. Providers are beginning to see the proverbial writing on the wall. Those providers who take on patient risk and manage it well will be financially rewarded and can differentiate themselves in the market. Those who do not manage risk and stay the fee-for-service course will continue to face lower payments and potential market share erosion.

Not all providers, however, are inexperienced at managing patient risk. This paper will discuss the best practices of some such providers who practice the principles of population health management.

The Fundamental Principles of Population Health Management

Population health management is a proactive, patient-centric approach to health and healthcare that engages patients and physicians in prevention, wellness, care coordination and care management with the goals of improving outcomes and reducing costs. For years, payers have been investing in targeted population health management programs focused on disease management and care management, with mixed results. Using remote care management teams and dated claims information, their programs operated from a limited and reactive perspective. The programs typically targeted the top one to three percent of a population with specific conditions using remote outreach models that were not integrated or aligned with the physician.

In accountable care models, however, provider organizations take responsibility for the health, care and overall costs of a defined population. Physician-led population health management can work better not only because physicians have face-to-face access to patients but also because they have access to real-time patient data. These advantages allow organizations to structure care teams led by physicians or care managers that can engage patients quicker and closer to the point of care.

There are five fundamental principles to a successful population health management program:

1 Physician engagement
2 Information transparency
3 Provider incentives
4 Population scale
5 Patient engagement

Of all the principles that enable population health management, the critical variable is the engagement of the individual physician. No matter the clinical expertise, the processes or the technology the provider organizations have in place, physician-based population health management programs will be hindered if physicians aren't on board and engaged in building the programs.

Care coordinators are key players for population health management programs. Often a role filled by a registered nurse, care coordinators interact with patients outside of a clinical environment in person, by phone, by chat or by email. But when a care coordinator first tries to interact directly with a patient, especially a high-risk patient, the patient is often confused and calls his or her physician. If that physician doesn't understand, isn't aware of or simply doesn't believe in the benefits of care management, that physician can limit the patient's engagement or adherence to the program.

Doug Allen, MD, Optum's chief medical officer of collaborative care and formerly the vice president of clinical operations of CareMore Health Plan, has seen many types of successful population health programs, some of which bypassed physicians. He notes the quickest way to success is to get physicians informed and supporting the programs.

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"Some provider groups have found ways around having to interact with the physician regarding population health management," Dr. Allen said. "At CareMore, the organization established close relationships between patients and CareMore's nurse practitioners before our members saw their primary care physician for the first time. But most groups are probably not in that position. If medical groups haven't successfully branded their population health model to the patient, they are at risk of having it undermined, either accidentally or on purpose, by the physician."

Provider-based population health management programs not only need physician buy-in, they also need physician participation. To thoroughly engage physicians, provider organizations succeed through transparency, incentives and scale.

WestMed Group, Purchase, N.Y., is a multi-specialty clinic that has been practicing population health management for the better part of a decade. Simeon Schwartz, MD, WestMed's president and CEO, said his group is guided by transparency.

"At WestMed, we do not tell physicians what to do; we show them what they are doing," Schwartz said. "You might have the best analytics around, but analytics are only good if you share the information transparently. You have to create a physician culture that allows for a high level of transparency."

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Data transparency may sound like an obvious capability, but translating data into information to share transparently can be difficult. Accessing the right data and analyzing it correctly takes a combination of clinical knowledge expertise, medical informatics acumen and technological capabilities. Even with the right pieces in place, physicians still need to be convinced to trust the data and change behavior based on the information. Creating a culture of transparency takes persistence in sharing information in an easy, consistent and accessible way. But with persistence comes change.

WellMed Medical Management is an innovative health care delivery system operating in the greater San Antonio area, as well as in Orlando and central Florida. It provides medical risk management and care management for 87,000 patients and health plan members—mostly seniors. The WellMed group in San Antonio employs more than 50 primary care physicians and works with more than 100 affiliated primary care physicians, all of which are supported by WellMed care managers.

Since its founding, WellMed had been consistently meeting with affiliated physicians to talk about financials, membership and patient acquisition strategies. When WellMed wanted to focus more on risk management during such meetings, it took a step-wise approach. Initially, WellMed starting discussing hospitalized patients with physicians and what would likely happen to them after they were discharged. When physicians were comfortable with these discussions, WellMed started asking the physicians who among their patients the physicians thought was high risk, and why. After physicians were comfortable discussing risk, WellMed introduced its risk stratification model. According to Efrem Castillo, MD, the group's San Antonio regional medical director, most physicians appreciated the insights into their patient population.

In fact, sharing risk stratification information has had a transformative effect on some physicians. One affiliated but independent physician was so taken by WellMed's risk reports—which categorized high-, medium- and low-risk patients using red, yellow and green indicators—that he customized his office's EMR to highlight his patients in red, yellow and green, based on their individual health risk.

"It was a lot of extra work, but the physician's intent was to figure out who is really sick," Castillo said. "So if someone called for an appointment and the patient's name showed up as red, the physician's staff would know the patient needed a same-day appointment—no questions asked. If the patient's name showed up as green, his staff would triage the patient to determine the best clinical follow-up."

"By sharing information, you're also assigning accountability," said Optum's Doug Allen. "You give physicians a performance profile for those patients for whom they are accountable. But you need to pay them for the additional time it takes to address all the extra needs of their patients."

In today's environment, addressing the needs of high-risk populations typically isn't a reimbursable activity. As we move toward accountable care models, physicians need to be incentivized to participate in population management activities.

Simeon Schwartz of WestMed said his clinic plans to withhold five percent of gross revenues as an incentive to meet targets for patient satisfaction and quality measures. WellMed shares individual incentives on a quarterly basis, usually in a meeting with all the affiliated physicians present. Dr. Castillo said the physicians get very motivated when they see one of their peers get a large incentive check because they met their quality metrics.

But while incentives are needed to encourage physician participation, Dr. Schwartz cautions against using practicing physicians to lead care management teams.
"You cannot continue to flog primary care physicians with more work and more responsibilities and expect their productivity won't suffer," Dr. Schwartz said.

Eventually, being paid to manage rather than treat patients will be par for the course. Medicare is already phasing out incentives for its Physician Quality Reporting System (PQRS) and replacing them with penalties. In 2015, providers who don't report enough quality measures will be subject to a one-and-a-half percent cut in reimbursement. That penalty rises to two percent in 2016. Look for other federal, state and commercial incentive programs to follow suit.

Incentives work, but the right variables also need to be in place. It's hard for provider organizations to incentivize for care quality and patient satisfaction, for example, unless they manage a sufficient number of lives. WellMed's Dr. Castillo said it's critical for organizations to manage large patient populations for incentives to work.

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"I'm not going to get a great response if I go to a physician and say, 'You manage 20 of my members; I want you to do spend additional clinical time with them,'" said Dr. Castillo. "To ask someone to alter the way they practice for just 20 patients—that is a tough pill for anyone to swallow."

For WellMed's efforts in Texas, where it manages 80,000 Medicare beneficiaries, its size and scale works well. In Dr. Schwartz's experience in New York state, he says the scale for population health management is correct when an ACO is affiliated with at least 1,000 physicians and has a service area that includes a million people.

Even if you have spent significant time and resources getting your physicians primed and ready for population health management, there's a key ingredient that can't be overlooked: the patient. Patients are ultimately responsible for their own health, and that fact is one of the concerns physicians have with accountable care. What if I do everything right, some say, but I'm stuck with patients who don't want to do the right thing? It's a valid concern. Studies have shown that half of chronically ill patients do not follow long-term treatment plans.

Just about every patient wants to be healthy. The key is to engage them in a way that makes sense to them, said John Wilson, MD, vice president of product analytics at Optum.

"No two patients are the same," Dr. Wilson said. "In my opinion, a good physician recognizes that all patients have their own concerns, needs, fears, expectations and hopes—with any condition, whether they're at a perfect spectrum of health or whether they're terminally ill. I think that one of the things we try and do is put people into high-level buckets, and information does not resonate with them."

The Fundamental Principles Drive the Core Processes

Successful population health management requires the right processes to deliver value to the system. The concepts are straight-forward: help the healthy stay healthy, help those with acute conditions get healthy and help those with chronic conditions manage their illnesses.

Core processes within physician-led population health management include:

- Identify patients
- Define the right population health management programs
- Design the programs
- Engage and educate the physician on the programs
- Engage the patient
- Measure the success

Finding the patients in need of care management takes data and concerted effort. Drs. Allen, Castillo and Schwartz mentioned three ways to find needy patients: analytics, sentinel events and physician involvement.

Analytics require data, and, according to Dr. Allen, the standard data types for population health management come from electronic medical records, lab values, pharmacy data and medical claims data. These data points, analyzed with a predictive modeling engine, can help organizations build a comprehensive picture of a patient's health risk.

Sentinel events, such as hospitalizations or emergency room visits, can inform population health management programs. While such events are what these types of programs are hoping to avoid, not all sentinel events should be considered care

management failures. Even with the best preventive medicine, some high-risk patients are going to need acute care. And while patients can often be convinced to follow care instructions, they can't be controlled.

Physician observation is an invaluable source for identifying high-risk patients. Doctors should be encouraged to volunteer information about a patient's suitability for any care management programs you offer.

Dr. Castillo's example of stratifying patients into high-risk, medium-risk and low-risk pools could be considered a best practice for provider-based population health management. But that begs the question: What do you do with the high-, medium- and even low-risk patients once you have identified them?

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Most successful care management programs organize their at-risk interventions by diseases or disorders. Common programs include asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease and other chronic, high-cost conditions. Programs can be built for any condition to which an organization's population is found to be susceptible. The Department of Health and Human Services' Agency for Healthcare Quality and Research has published guidelines to help state Medicaid systems develop care management programs. It is recommended reading for any organization getting its start in population health management.

We know that when physicians are on-board with population health management, patients are more likely to engage, but engaging patients requires more than physician buy-in. Provider organizations need to stop looking at themselves solely as providers of medical services. They also need to look at themselves as facilitators, who not only provide care when needed but also get their patients involved in the management of their health.

Of course, interventions are less likely to be needed when chronic patients are well-managed and healthy patients stay healthy. Therefore, population health management programs need a high dose of prevention and wellness. Currently, investments in prevention and wellness programs are low and are typically provided by the payer or the employer, due to the long-term pay-off. As provider organizations move to fee-for-value, they will need to develop programs—independently or in partnership with the payer or employer—to help individuals proactively manage their health.

A multi-channel outreach plan based on the individual's desired communication and level of activation is essential to engage patients. For high-risk patients, a recommended program involves outreach by the physicians, nurse practitioners and other clinicians and care managers as well as services, portals and tools that support secure messaging, personal health management tools and social media. Emerging solutions include personal health management tools that provide interactive solutions to support consumers in managing their health and conditions. This can include health and condition education and tools that can help track exercise, diet and medication routines.

High-risk patients need more than communication—they often are in need of one or more interventions. Interventions instituted by care management programs can vary widely, according to Optum's Doug Allen, from in-home devices that monitor patients to nurse practitioners who check on patients by telephone or in person. The key is to use data to measure the intervention's effectiveness.

"You build that intervention tool chest and then you see where you are," Dr. Allen said. "Based on how effective your interventions are, you adjust your tactics and continue to improve the effectiveness of your program."

Medium- to low-risk patients also need to be engaged, using some portion of the aforementioned communication elements. An important consideration in any program is to try to keep low- and medium-risk patients from becoming high-risk patients. The keys, again, are data and a cost-effective set of interventions that put the data to use.

"I am always looking for ways to get information around the patients more readily and more accurately and in a more robust manner," Dr. Allen said. "For example, even with the breadth of the data in Optum's data warehouse, we don't have real-time lab results. We're starting down that road, so when a patient has a baseline high level of creatinine, then we see it rise rapidly, we know immediately the patient has an urgent kidney problem and can act on that information quickly. If we can find problems like that in our daily analysis, we can take quick action through a nurse practitioner or physician."

Finally, measuring success, on both a macro and a micro level, is essential. Measurements should evaluate results on a month-to-month, month-to-previous-year's-month and year-over-year basis. Monthly macro-level metrics show organization leadership their programs' impact on quality, utilization and cost. This information should be provided both on an overall population level and on a program (disease or condition) level. Monthly micro-level metrics provide care teams with information on actionable clinical, utilization and operational metrics to quickly identify trends. Specific interventions can then be identified to better manage processes and resources.

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The Technology that Makes Population Health Management Work

In population health management, technology is where principles and processes meet. Technology is the means by which organizations identify high-risk populations, outlying physicians and effective interventions. All of this can be done without technology, but technology makes the process faster, easier and smoother.

Supporting population health management requires an integrated solution that supports patient care delivery, care management, care follow-up and patient engagement. The application infrastructure includes:

- Electronic Health Record
- Health Information Exchange (HIE)
- Analytics and Predictive Modeling
- Care Management Platform

Electronic Health Records (EHRs) are the primary interface for clinicians to capture and manage information collected during patient encounters, but they should only be considered a starting point for population health management. EHRs do not support comprehensive prevention and chronic care, and they do not generate quality and population reporting needed to measure success.

Creating additional challenges, information is often locked within the EHR database. Since sharing information is critical for success, another essential technology is a health information exchange (HIE) to facilitate movement and consolidation of data between the various accountable care partners.

Other technologies that facilitate the flow of data, information and communication include personal health records (PHRs) and patient portals. PHRs help organizations gather patient-supplied data and engage patients in their own health maintenance. Patient portals also engage patients, provide health management tools and gather data, and allow for secure clinician-to-patient communication.

Population health management thrives on data, but getting quality, actionable data from multiple internal and external systems is a constant challenge. As separate organizations partner to create ACOs and other value-based arrangements, integrating data into a virtual or central data warehouse is a must to manage costs and improve quality.

Real-time data integration through the use of the HIE is critical to making health care data actionable. Integrating data across multiple organizations or within a single organization is a big undertaking. Security and privacy protocols must be considered. Source data compatibility must be addressed through data normalization, standardizing clinical nomenclature, defining data relationships and instituting quality controls. Before such processes even start, ensuring the right data is accessed takes careful, thoughtful planning.

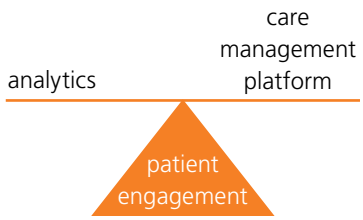
With good data as a foundation, accountable care organizations will want to put that data to work. Analytics and predictive modeling tools will help organizations support population and individual population health management. The tools help organizations identify high-risk patients, predict with a high degree of certainty if a patient could become high risk, determine the most effective interventions for a given population and analyze clinical performance.

Optum's Doug Allen said his organization's care coordination efforts are based on Optum tools that not only identify high-risk populations but also predict outcomes such as who has the highest potential for hospitalization within the next 12 months or who will be a frequent emergency department visitor. WestMed's Simeon Schwartz provides his physicians with data dashboards that highlight specific patients in need of interventions. WellMed's EHR has incorporated evidence-based protocols that query physicians based on the patients' conditions and best practices. WellMed's Efrem Castillo also sees tremendous value in leveraging data to persuade physicians to improve the way they practice.

"It's really nice to walk into a physician's office and say, 'What do you think? What should you do about this?'" Dr. Castillo said. "But then you also need to have a way to 'show them the money'—the effect that care improvement has on their bottom line."

"I think that actually takes software and people—people who the physicians respect who can sit down with them and say, 'This is where the gaps are; this is how you can do better,'" Castillo said.

When it comes to patient engagement, analytics are the first half of the equation, helping organizations define their population risk levels. The second half of the equation is a care management platform that supports individual patient interventions using real-time clinical information.



Care management platforms need to adjust to the realities of physician-led population health management. Most current platforms do not utilize real-time clinical information, nor do they dynamically update patient risk levels and care opportunities. Many of today's platforms use outdated claims information, missing opportunities to engage and support patients closer to their episode of care.

In addition, many of today's care management platforms focus only on chronic conditions. A new generation of care management solutions can enable providers to track a patient population to ensure optimal delivery of preventive care. Such broad-stroke preventive interventions can help improve the health of all, and make good use of a physician's time and system resources.

According to Optum's Dr. Wilson, care management platforms work best when they stratify patient risk, support registries, find gaps in care—relative to both prevention and chronic care—identify and track variances in care, and facilitate care management/coordination, including care tracking.

"Within our particular platform, we're building a holistic view of a patient using real-time clinical information and claims records," Dr. Wilson said. "We're building that view in such a way that we can identify the classic gaps-in-care opportunities, but we can also manage the care of the patient within the context of the system. As such, Optum Care Suite has a focus on measurement and management. It measures things like cost and risk, for example, but it also enables patients to be ascribed to a patient-centric care management program directly from inside the application."

For example, many care management systems can identify a patient that requires a colorectal screening and auto-send that patient a message. But if that particular patient is depressed and borderline suicidal, the last thing he or she needs a reminder about is a colorectal screening. Personalizing the care management approach at the individual patient level becomes incredibly powerful. In the Optum Care Suite, real-time information allows for the patient outreach to be focused on the depression, not on the colorectal screening.

Such applications are meeting the objective of population health management, helping providers act instead of react by proactively identifying opportunities for intervention and for care improvement.

Conclusion: Population Health Management Is Part of the Cure for What Ails Health Care

Provider-based population health management is integral to reforming health care in the U.S. By embedding the principles, processes and technologies of population health and care management into the provider community, we have a better chance of managing outcomes and healthcare costs. As providers deliver the care and are closest to the patient, they have the ability to proactively engage individuals in their own health.

"The traditional American health system does not reward coordination, efficient use of resources or higher quality healthcare," Dr. Allen said. "When we improve quality and decrease costs, by definition we're improving the value of the care delivered. To do so, we need to manage the patients in a more coordinated manner, in a more efficient manner and more effective manner, and that is best done through population health management."

About Optum

Optum is an information and technology-enabled health services company serving the broad health care marketplace, including care providers, health plans, life sciences companies and consumers and employs more than 30,000 people worldwide. For more information about Optum and its products and services, please visit **www.optum.com**.

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T 800.765.6619 | **www.optum.com**

13625 Technology Drive, Eden Prairie, MN 55344