Guide to Population Health Management

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Executive Editor’s Note

Welcome to the Healthcare Intelligence Network’s Guide to Population Health Management. The continuum-spanning approach of population health management — from keeping the healthy ‘healthy’ to coordinating care for complex patients and those with advanced illness — supports the widely embraced Triple Aim of healthcare: offer affordable care that improves the experience of each individual and the overall health of the population.

According to 2012 market data by the Healthcare Intelligence Network, 58 percent of healthcare companies are taking a population-based approach to health management, versus the traditional silo approach to disease management. Almost half of those with no population health management (PHM) program will launch one in 2013, the data indicates.

Case managers, health coaches and primary care providers are being engaged in PHM programs nationwide.

The Guide to Population Health Management lays the groundwork for a PHM program, providing a comprehensive set of 2012 PHM benchmarks from 102 companies and strategic advice from early adopters of a PHM approach.

It also offers a primer in PHM, an advanced case study in the use of analytics in PHM, and an examination of PHM tools at work in the accountable care organization (ACO), a new value-based healthcare delivery model that has emerged post-ACA.

Additionally, acknowledging the essential contribution of technology to a PHM initiative, this 130-page guide takes a deep dive into the use of patient registries, demystifying registry use and identifying best practices, such as the use of registry data to identify gaps in care and the evolving role of patient registries in delivering accountable care.

Answers to more than 40 critical FAQs on population health management are provided.

- Chapter 1: 2012 Benchmarks in Population Health Management
- Chapter 2: Profiting from Population Health Management: Applying Analytics in Accountable Care
- Chapter 3: Population Health Management Tools for ACOs: Technologies and Tactics to Support Accountable Care

Applying the best practices contained in the Guide to Embedded Case Management will help healthcare companies to better identify, manage and reduce health risk in the populations they serve.

Melanie Matthews, HIN executive vice president and chief operating officer
2012 Healthcare Benchmarks: Population Health Management

102 healthcare organizations described their efforts in population health management, including the areas covered by the PHM program, the tools used to promote engagement, the incentives that are offered for participation, and more.

“Risk stratification and score are our [most effective tools in use in our PHM program].”
> Hospital/Health System

“Improved quality on numerous primary and secondary prevention metrics (most based on HEDIS), and a reduction in total cost of care (TCOC) for pilot population were the [greatest successes we achieved with our PHM program].”
> PHO

“[Our program expansion plans for the coming year] will include an extensive seven new sites with case managers who will increase provider engagement and system support.”
> Hospital/Health System

“[The most effective tool in use in our PHM program] is our EMR.”
> Staff Model HMO
2012 Healthcare Benchmarks: Population Health Management

This special report is based on results from the Healthcare Intelligence Network’s “Population Health Management in 2012” e-survey administered in September 2012.

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About the Healthcare Intelligence Network

The Healthcare Intelligence Network (HIN) is an electronic publishing company providing high-quality information on the business of healthcare. In one place, healthcare executives can receive exclusive, customized up-to-the-minute information in five key areas: the healthcare and managed care industry, hospital and health system management, health law and regulation, behavioral healthcare and long-term care.

Executive Summary

As ACA reforms continue to impact the healthcare industry, population health management (PHM) is fast becoming the new buzzword for the management, integration and measurement of all health programs offered by an organization — a set of interventions aimed across the health continuum, from the healthiest employees or health plan members to those with catastrophic illnesses. It’s a rapidly growing shift in healthcare, as the industry moves away from rewarding quantity over quality and volume over value and toward chronic disease management and preventive health management.

As we discovered in HIN’s first annual Population Health Management survey conducted in September 2012, key to this movement is the focus on the whole population, with 83 percent of respondents citing the use of health promotion and wellness programs over disease management (75 percent) and HRAs (69 percent). Case managers continue to leave their imprint on the healthcare scene; 64 percent of respondents consider them part of their PHM team. And 79 percent say health coaching is a vital part of their PHM program, with 78 percent of those favoring telephonic delivery of health coaching. The often underutilized telephone is considered a key modality for PHM program delivery, and preventive services reminders (81 percent) are the primary tool used to promote consumer engagement and participation.

But despite metrics showing a jump in patient compliance (reported by 54 percent), 42 percent of respondents said that patient/member engagement was the greatest challenge posed by PHM.

Survey Highlights

- More than half of respondents have a PHM program in place.

- Case managers are the most crucial elements of an effective PHM team, reported 64 percent of respondents, slightly edging out PCPs (60 percent) and health coaches (55 percent).
Figure 1: All - Have Population Health Program

*Do you have a formal population health management program?*

- Yes: 58.0%
- No: 42.0%

Figure 2: All - Areas Covered by Program

*Which areas are covered by your PHM program?*

- Health promotion: 83.3%
- HRA: 68.8%
- Care coordination: 60.4%
- DM: 75.0%
- Case management: 66.7%
- Other: 16.7%
Profiting from Population Health Management:
Applying Analytics in Accountable Care

This special report is based on two 2012 Healthcare Intelligence Network (HIN) webinars hosted by Melanie Matthews, HIN executive vice president and chief operating officer. This report is aimed at CEOs, medical directors, wellness professionals, human resources professionals, disease management directors, managers and coordinators, health plan executives, care management nurses, business development executives and strategic planning directors.

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Profiting from Population Health Management: Applying Analytics in Accountable Care

As ACA reforms continue to impact healthcare, population health management (PHM) is fast becoming the new buzzword for the management, integration and measurement of all interventions across the health continuum, from the healthiest populations to those with catastrophic illnesses. Rooted in the IHI’s Triple Aim, PHM dives deep into health analytics to reduce risk and associated health spend and provide a strong foundation for accountable care in a value-based system.

This special report provides both a primer in PHM, identifying the challenges and opportunities of a robust population health management program, as well as an advanced case study in the use of analytics in PHM.

Population Health Management: Achieving Results in a Value-Based Healthcare System

Healthcare costs are projected to rise at a slower rate than they have been in the past, but this year alone companies are expected to pay about $10,000 for each employee in their population. We conduct an annual global wellness survey. The most recent results indicated that about 80 percent of employers either don’t know if their programs are working or they don’t believe that they are working.

Many of those same employers tell us that their top three objectives for health management are to reduce healthcare costs, decrease absences and improve productivity. In order to achieve those objectives while still remaining competitive, they must focus their activities on driving lower healthcare costs.

There’s no single factor responsible for the rising healthcare costs in America today. Our system is complex and there are numerous cost drivers. Some of those drivers include the population aging. The median age in the United States today is about 43, and someone turns 50 years old every six seconds in America right now. And we know that people over the age of 50 consume the most healthcare.
Population Health Management
Tools for ACOs: Technologies and Tactics to Support Accountable Care

This special report is based on two 2011 Healthcare Intelligence Network (HIN) webinars hosted by Melanie Matthews, HIN executive vice president and chief operating officer. This report is aimed at CEOs, medical directors, wellness professionals, human resources professionals, disease management directors, managers and coordinators, health plan executives, care management nurses, business development executives and strategic planning directors.

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