Population Health Management & the Medical Neighborhood

Patient Centered Primary Care Collaborative
Monthly National Briefing
September 26, 2013
Outline

- What is Population Health Management?
- Registries
- Health Risk Assessment
- Risk Stratification/Predictive Modeling
- Patient Enrollment
- Communication
- Enter Case Management
- “Care” vs. “Case” Management
- Some Published Data
So...what is “Population Health Management?”

**AHRQ Definition:**
An approach to care that uses information on a group ("population") of patients within a primary care practice or group of practices to improve the care and clinical outcomes of patients within that practice.

**Vendor Definition:**
- Physician guided, proactive, accountable and patient-centric population approach to care, that is.....
- Designed to enable informed and activated patients address both illness and long term health.....
- That relies on the integrated involvement of all health care professionals who coordinate with the patient, caregivers and families.

Three core principles:
1. Primary care physician leadership
2. Patient activation, involvement and personal responsibility;
3. Programs of coordination ranging from wellness to chronic case management
Population Health Management in the Neighborhood

Registries: Population Monitoring/Identification

Risk Stratification: Care Gaps
- HRA
- Medical Claims
- Lab Data
- Other

Patient Enrollment/Engagement

Care Management
- Mail
- eMail
- Telephone
- Internet/Intranet
- Social Media
- Face-to-Face Visits

Tailored Interventions / Provider Interventions

“In Trans” Organizational Interventions
- Culture / Environment
- Health Promotion, Wellness, Preventive Services
- Health Risk Management

Organizational Care
- Integrated/Coordinated Care and Clinical Referrals
- Care Coordination/Advocacy
- Telemanagement
- Telemonitoring Portals
- Disease/Case Management
- Specialty Referral

Incentives & Rewards
- Incentivize Enrollment/Engagement
- Reward Participation, Outcomes
Registries

A medical home/neighborhood’s searchable data warehouse

Inputs:
1. Electronic health record….
2. Administrative and insurance claims data….
3. Health surveys (especially for new enrollees)….
4. Public databases?
   • Very much an evolving science
   • Economies of scale count
   • Enable “Big Data” research

Health Risk Assessment (HRA)

Any survey that objectively estimates chances of outcomes from selected causes within a defined period of time

- HRAs can be used to:
  - notify an individual (and provider) of global or disease specific risk and/or
  - can also be used for provide summary statistics for program planning
  - Workflow! Typically not used by physicians for their patients in day-to-day clinical care.

http://www.innovations.ahrq.gov/content.aspx?id=2282
Risk Stratification

Statistical associations that array vulnerability from high to low based on:
1. “Actionable” care gaps
2. Willingness to change

“Vulnerability” is…..
- patients’ future “trajectory” into higher risk categories such as hospitalization, death or “avoidable claims”

Other predictions: obesity, diabetes mellitus and other chronic conditions.

Detects “invisible” patients

Once again:
1. Workflow: Typically not used by physicians for their patients in clinical care
2. Equitability: should patients be moved to the front of the line?
Uneven Distribution of Risk
~ Not All Hypertension is Created Equal ~

Patient Enrollment

- Clinically & culturally appropriate referral and recruitment into programs
- Multiple channels, including mail, telephony and social media
- Opt-in” vs. “opt-out”
- Incentives are an option
- Recruitment rates typically run 5-15% thanks to limited patient incentives and lack of physician buy-in, time and compensation of work effort.
A Word on Patient Engagement

- Old: print materials, one-on-one face-to-face and telephonic instruction
- New: education that leverages behavior change using psychological principles of recruitment, assessment of barriers, formulation of strategies to overcome barriers, goal setting, coaching, support and follow-up.
- Includes “texting,” variations of email and social media such as Facebook.
- New approaches: “shared decision making” and “patient centered care.”
Enter Case Management

- Collaborative assessment, planning, facilitation & advocacy for care services that meet an individual's health needs through available resources that promote quality cost-effective outcomes
- Provides education, informed decision making and a care plan that coordinates insurance benefit designs, psychosocial issues, input of family, community resources and the physicians’ judgment.
- Associated with greater frequency of self care, control of lifestyle behaviors, problem solving, medication compliance and improved outcomes
- Advocates for social factors such as access to good housing, places to exercise, safe neighborhoods, and health food sources
- Another point of access to the health care system
- Meets all of the challenges from the prior slides:
  - Include the HRA in care planning
  - Use predictive modeling to prioritize patients and needs
  - Facilitate patient enrollment
  - Pursue engagement
  - Coordinate programs, referrals, social factors

Nurses: your ship has come in

http://www.medpagetoday.com/Washington-Watch/Reform/41125
“Case” vs. “Care” Management

**Case Management**
- the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes
- **Individual, high touch, high intensity**

**Care Management**
- Package of physician supervised interventions that assist patients & their support systems in managing medical conditions and related psychosocial problems.
- Seeks to improve patients’ functional health status, enhancing the coordination of care, eliminating the duplication of services, and reducing the need for expensive medical services
- **Populations, high tech & medium intensity**
Care vs. Case Management

Low Risk, Low Cost

*Chronic Care*
Medium Cost, Manageable Risk

The “Boundary” is Flexible

High Risk
High Cost

Number of Enrollees

Risk or Care Gaps or Costs/Charges per Member
Why Care/Case Management
An Emerging Opportunity for Collaborative Teaming

- Provider organizations, care management companies & managed care organizations agree:
  - Physician leadership
  - Teaming
  - Accountability
- Studies are demonstrating credible cost-savings\(^1\)
- Offer patients another pathway to primary care\(^2\)
- Growing interest among regulators, policymakers and government in remotely-based care management & telemonitoring programs

Features of Successful Care and Case Management

Health Professionals Who Are...

Mobile
Interact with patients than once a month

“Top of license”

Connected
Full time dedicated

Credentialed

Telephonic & face to face

Patient self-care

Change Agents
# A Randomized Trial of Remote Care-Management Strategy

### Table 1. Risk Stratification, Outreach Criteria, and Coaching Techniques According to Cohort.

<table>
<thead>
<tr>
<th>Cohort*</th>
<th>Stratification</th>
<th>Outreach Criterion</th>
<th>Coaching Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjects with selected chronic conditions (heart failure, CAD, COPD, diabetes, asthma)</td>
<td>Predicted financial risk based on linear regression models</td>
<td>Lower cutoff point for predicted future costs in enhanced-support group</td>
<td>Behavioral change and motivational counseling</td>
</tr>
<tr>
<td>Subjects with preference-sensitive conditions that put them at risk for surgical intervention (lumbar surgery, knee or hip replacement or repair, cardiac revascularization, prostatectomy for benign prostate hyperplasia, hysterectomy or myomectomy for benign conditions)†</td>
<td>Predicted risk of surgical intervention based on logistic-regression models</td>
<td>Lower cutoff point for predicted future costs in enhanced-support group</td>
<td>Shared decision making</td>
</tr>
<tr>
<td>Subjects with other high-risk conditions (cardiac arrhythmias, angina, obesity, tobacco use, depression or anxiety, hypertension with complications, back and neck pain, osteoarthritis, hyperlipidemia, abdominal pain) or with multiple hospital or emergency room visits‡</td>
<td>Predicted financial risk based on linear regression models</td>
<td>Enhanced-support group only</td>
<td>Behavioral change and motivational counseling</td>
</tr>
<tr>
<td>All others</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* The cohorts were identified on the basis of claims data. CAD denotes coronary artery disease, and COPD chronic obstructive pulmonary disease.

† A preference-sensitive condition is one for which at least two valid, alternative treatment strategies are available. Since the risks and benefits of the options often differ, the choice of treatment involves trade-offs; therefore, the choice should depend on informed patients making decisions on the basis of their preferences and values. This group had none of the selected chronic conditions.

‡ This group had none of the selected chronic or preference-sensitive conditions.

Enhanced vs. Usual Support, According to Service Category.

Case Management, PHM, Physician Reality

The majority of care in many areas of the U.S is still provided by small physician-owned practices

PHM Interventions made up of:

- a health risk assessment,
- risk stratification with predictive modeling that identifies patients at greatest need
- a registry that enrolls and tracks patients and their pertinent outcomes over time
- use of aggressive patient enrollment strategies using an opt-out approach
- supporting providers and patients with evidence-based clinical guidelines that guide decision making
- facilitating the establishment of tailored interventions that are documented and supported by care plans

Primary care settings that are:

- Community based
- High performing
- Willing to participate
- Typically significant number of patients who are discharged from an inpatient facility or skilled nursing setting
- A sufficient number of high risk and “impactable” individuals with care needs to warrant care and case management
- Agreeable to having ready access of the care manager to the non-physician personnel in the clinic

...CAN BE SUCCESSFULLY INTEGRATED WITH...

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“Researchers claim that during an average meeting webinar, each idea is met with nine criticisms”

Lance H.K. Secretan: *Reclaiming Higher Ground: Creating Organizations that Inspire the Soul*

Questions?

For follow-up......

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Disease Management Care Blog