IT'S TIME!

POPULATION HEALTH MANAGEMENT: YOUR CHECKLIST FOR SUCCESS

Have you ever thought about the similarities between managing the healthcare of your total patient population and raising children?

Parents must care for and support children on a comprehensive, continuous and proactive basis – including encouraging them to do the things they may not want to do, like homework. So, too, must doctors keep the patient front and center in their minds, doing their best to ensure that they receive appropriate health screenings, get their immunizations, and follow care plans for preventive and chronic care, among other treatments.

Sometimes, they must do all this in the face of patients who resist their best efforts, patients over whom they have far less control than parents have over their children. Clearly, it's no easy task, but so much depends on doing it well – quality performance scores, reimbursements, and reputations as the Centers for Medicare and Medicaid (CMS), and increasingly private insurance companies, change healthcare payment structures.

How do you meet the challenge of population health management as the pendulum swings toward value-based care? Here are three steps that can help your practice be successful in its endeavor.

Action Item 1: Assess your overall population.
Just who are you caring for in your practice? Key clinical, claims and demographic data can provide insight into how your patient practice breaks down and what that means in terms of care oversight.

You'll want to know, for example, who is at high risk and needs the most constant contact, such as individuals with multiple chronic diseases and/or those who require technologies such as ventilators; who has chronic but less serious conditions that require some level of monitoring; and who is in good health and need just the occasional notice about preventive care steps they can take, whether it's a flu shot or an annual check-up. You'll also want to understand who among your patients generally is in good health but is experiencing a temporary issue that requires a little more regular attention, whether it's monitoring a difficult pregnancy or seeing an otherwise spry senior citizen through the right course of treatment after a damaging fall.

Gaining such knowledge is a smart first step to enhancing the quality, cost, safety and efficiency of care at the individual level as well as across sub-populations (for example, patients with diabetes or heart conditions), while improving business performance.

Action Item 2: Gear up to act on patient assessment knowledge.
Once there's more clarity around risk stratification and the kind of management needed for all a practice's different patient sub-populations, it's important to be organized to perform those services.

That organization will come in the form of having structured and effective systems, policies, procedures, and practices to create, document, execute, and update a plan of care for every patient and sub-group. Greater automation within electronic health records (EHR) systems, for example, can facilitate different service reminders delivered via email to various patient populations. Policies and procedures also can be determined to ensure that your practice operates effectively as part of care coordination programs, covering procedures for monitoring cases, making referrals to other specialists, and staying apprised of patient status. Segmenting patients according to multiple filters also helps optimize organizational practices. Ensuring that people are matched into care management programs that are clinically effective as well as operationally efficient makes it possible for a practice to use its limited care management resources most appropriately

Action Item 3: Engage patients, or dismiss them.
One of the most important things a provider can do

is build patient relationships that keep individuals engaged with their own healthcare. They must be motivated to collaborate with providers to manage their own health outcomes, and ideally this must be done as efficiently as possible to reduce manual workloads. That can start with the simple things, such as automated email reminders about appointments – and for the healthy among the entire patient population, that may well be enough.

For others with more serious or chronic conditions, higher-level engagement strategies may be required to inspire patient collaboration. For example, patients and doctors may need to schedule in-person goal-setting sessions. Or efforts may need to go into re-envisioning a care coordination program so that it is easier for multiple providers to connect with each other and with their common patients and their families, to enable better communication across the entire spectrum. It may even be possible to further streamline operations by automating these connections.

Doctors also must be prepared to take a difficult step when patients remain totally non-compliant: Tell them they can no longer treat them and ask them to find a different provider. Firing a patient isn't out of bounds when the individual refuses to cooperate at even basic levels, and especially as that lack of cooperation today may threaten to impact a physician's performance ranking, patient satisfaction scores and reimbursement.

Managing the health of your patient population is ambitious. In fact, experts at the Institute for Health Technology Transformation who wrote the report, Population Health Management: What It Is And Isn't, suggest taking incremental steps – such as beginning with automated patient outreach at primary care practices – and testing them thoroughly on a small scale before engaging the entire organization.

While moving in this direction is ambitious, it also is necessary and can't be avoided. In the same report, the Institute lays out why, concluding that "population health management is the key to accountable care and healthcare reform."

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