HW HealthTeamWorks Workforce_Development

3 Managing the Health of the Population

- Introduction & Learning Objectives
- Population Health Management Defined
- The Role of Information Technology and Data
- Population Health Management Simplified
- Primary Care Approach to Population Health Management
- Test Your Knowledge
- Activity Instructions

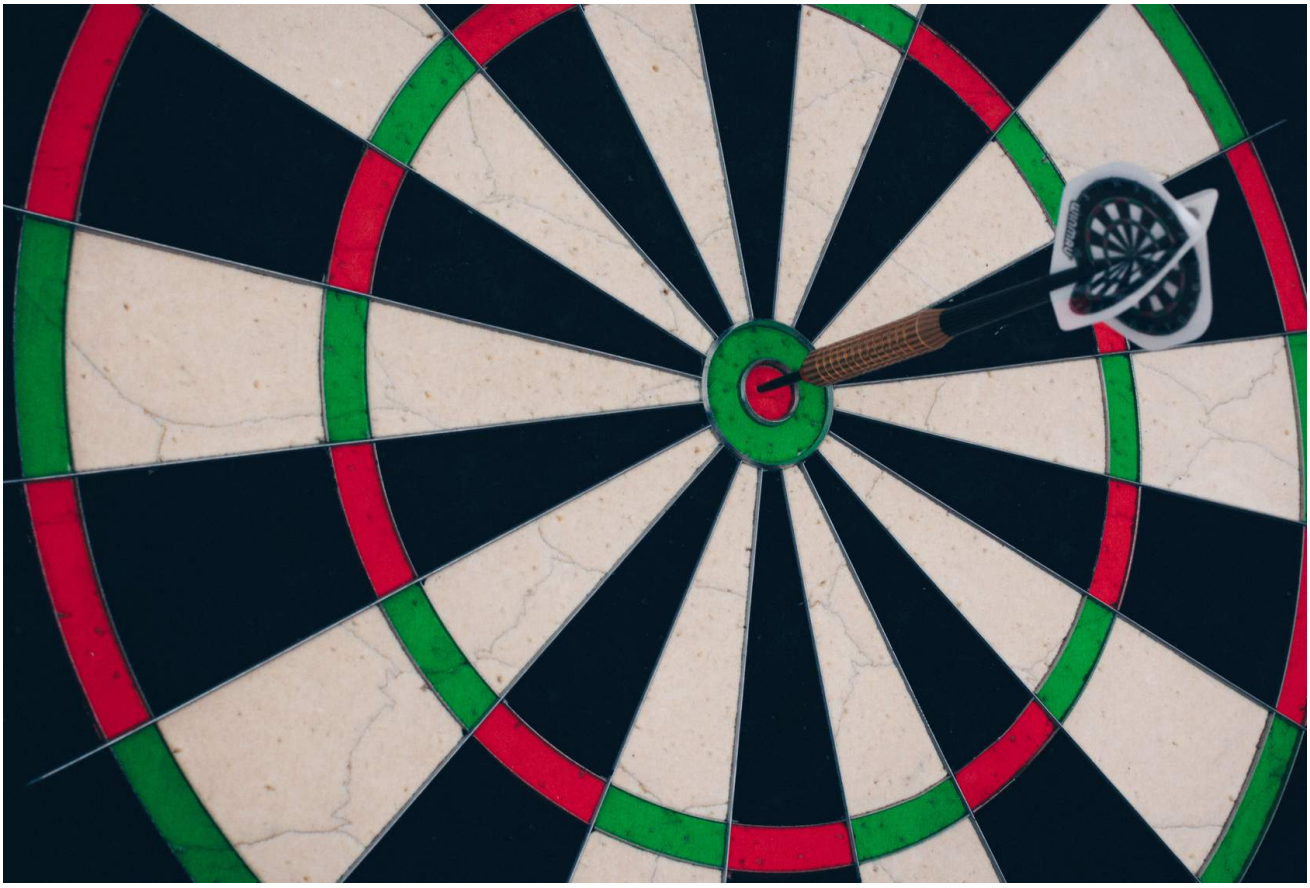
Lesson 1 of 7

Introduction & Learning Objectives

HW HealthTeamWorks Workforce_Development

01:35

Click here for Audio Recording



In this course, we are introducing the basic concepts of population management and why an understanding of these principles is important to a Care Manager. Looking at clinical care, population health management includes everything related to

management of the physical health of all individuals in a population (whether that individual is considered healthy, has chronic conditions, or is in a catastrophic medical state).

Aspects of this care include primary care providers, specialists, acute care (hospitals/ED), post-acute care in skilled nursing rehab and LTAC facilities, home care, ancillary services such as physical therapy, occupational therapy, speech therapy, and the providers of medical equipment needed to support patients in their clinical conditions. One of the key roles of the care manager is to help the patient manage these components of care in an efficient and effective manner.

Learning Objectives

Following the completion of this course, the learner should be able to:

- Define population health management and describe how it plays a part in care management.
- Distinguish the key components of population health management and determine methods to introduce them into your care management approach.
- Illustrate the importance of data in managing population health by participating in online discussion.

Lesson 2 of 7

Population Health Management Defined

HW HealthTeamWorks Workforce_Development

02:56

Click to Play Audio

Population Health was first defined by Kindig and Stoddart in 2003 as:

> "The health outcomes of a group of individuals, including the distribution of such outcomes within the group... the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link these two."
>
> - Kindig and Stoddart

More than fifteen years after population health was defined by Kindig and Stoddart, the concept and practice have spread. In 2016, a project sponsored by IBM Watson reported that over two-thirds of hospitals and health systems have initiatives involving population health management (A roadmap to population health management).

What has happened in the intervening years is that the concept of providing PROACTIVE care started to take hold, which is essentially what we now know as population health management. There are many different definitions of population health management, just as there are many different approaches to how to develop processes that manage an entire population.

At its core, the management of a population, no matter if you're in primary care, or a public health department, or a specialists office, means addressing all facets that impact the health and outcomes of the individuals within a given population. This includes:

- Clinical/medical care
- Mental and behavioral health
- Attention to social needs and social determinants of health

Mental and behavioral health should be well coordinated with primary care. Mental health can have a dramatic impact on an individual's ability to manage chronic conditions. As part of population health management, it's important for the practice to coordinate information sharing between agencies that support their patient's mental health, and even embed behavioral health (also called "behavioral health integration") into the primary care practice.

Lastly, the practice should address social needs and social determinants of health in their population health management efforts. Research has shown that only 20% of the relative influence on health outcomes can be attributed to the clinical care a patient receives. This means that there is a lot going on in patients' lives outside of the practice, and these are things that can dramatically impact the health and outcomes of that population. By including these facets of a patient's life into care and coordinating to meet needs, practices will garner better health outcomes.

So how does a practice, a health department, or even a health system, accomplish such a big feat?

Care must be planned, coordinated, and effective workflows developed. Additionally, it all has to be supported by robust Health IT Infrastructure.

All of these efforts combined will help us achieve greater quality, lower total cost, and improved experience for both the patients and the clinicians.

Lesson 3 of 7

The Role of Information Technology and Data

HW HealthTeamWorks Workforce_Development

02:36

Click to Play Audio

In order to be successful, an organization striving to develop an effective population management program must invest in robust information technology (IT) infrastructure and data analytics to support all of the aspects of the population health initiatives in which they participate. Components of this infrastructure include:

- A high-quality electronic health record (EHR) that will be the key repository for all clinical data.
- A care management platform with the ability to:
    - Develop care plans that can be tracked and updated,
    - Capture social determinants of health,
    - Document advanced care planning, and
    - Track referrals to specialists.
- Disease registries
- Patent portal capability within the EHR that:
    - Enables easy communication between patient or caregiver and the practice
    - Decreases the burden of phone calls and triage
    - Provides capability to implement e-visits

- A robust community-wide Health Information Exchange (HIE) to support the transfer of data between facilities
- A data warehouse
- Dashboards for ongoing transparency of data

Integration of claims data from payers (insurance companies) with existing health IT is incredibly valuable. Claims level detail about patients and populations can provide new and different insights into other aspects of their care that can help a practice improve outcomes. For example, access to pharmaceutical claims data will inform a care team whether or not a patient is refilling medications at regular intervals. Also, it can provide insight into the overall prescribing patterns of individual providers. There may be an opportunity for the practice to reduce overall pharmaceutical costs, and insight into the claims data can point to insufficient generic prescribing or other areas of opportunity.

Last, but not least, it is important to have skillful data analysts that can study the available data and inform the care team of opportunities to improve quality and reduce costs for the population. Additionally, well-crafted metrics that assess both process and outcome measure will inform the care team on successes and opportunities for improvement. Many practices have their metrics displayed in a dashboard that's available for the entire team to see. This level of transparency into the data is especially helpful.

Lesson 4 of 7

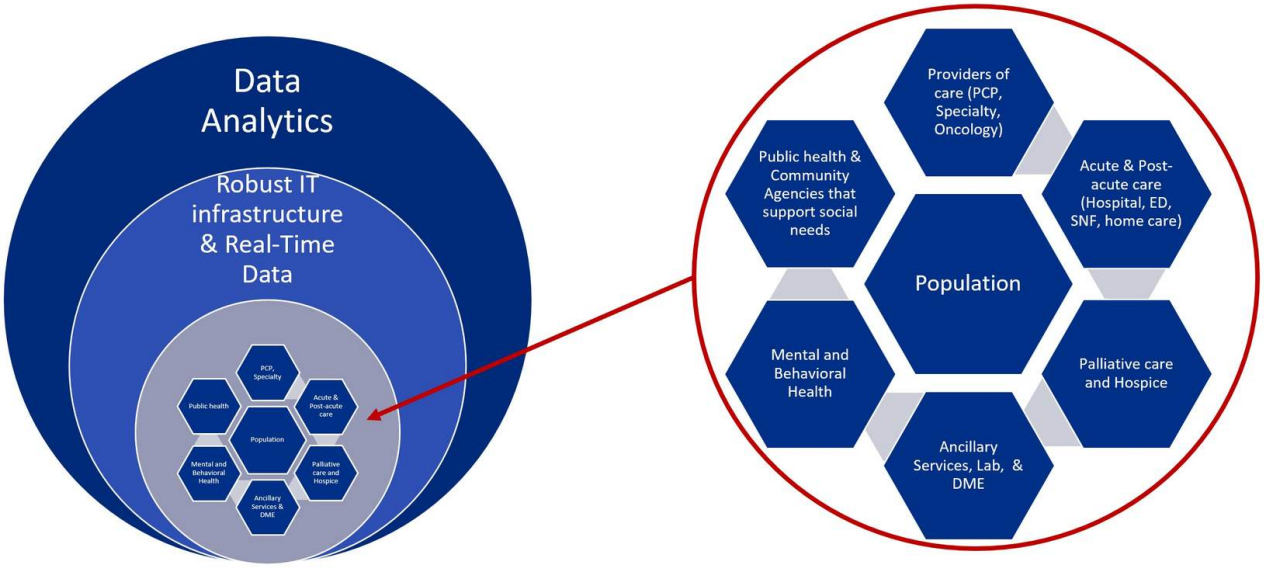
Population Health Management Simplified

HW HealthTeamWorks Workforce_Development

01:10

Click to Play Audio

The image below is a very simplified visual representation of the different facets of population health management described in previous modules.



At the center of the image, you will see the types of care that a population may require. This is not inclusive of all care, but it is a good place to start and includes the most common components. It is important to keep in mind that all aspects of this care must be coordinated.

Next in the diagram, is IT infrastructure, which wraps around all aspects of patient care and coordination. This includes EHR, HIE, claims data, etc. The IT is needed to provide and support effective care and ultimately,

support an effective population health program.

- Finally, surrounding all of this is data analytics. Data analysis supports the entire process and informs the care team about the health of the population, costs, outcomes, opportunities for improvement, etc.

Lesson 5 of 7

Primary Care Approach to Population Health Management

HW HealthTeamWorks Workforce_Development

01:11

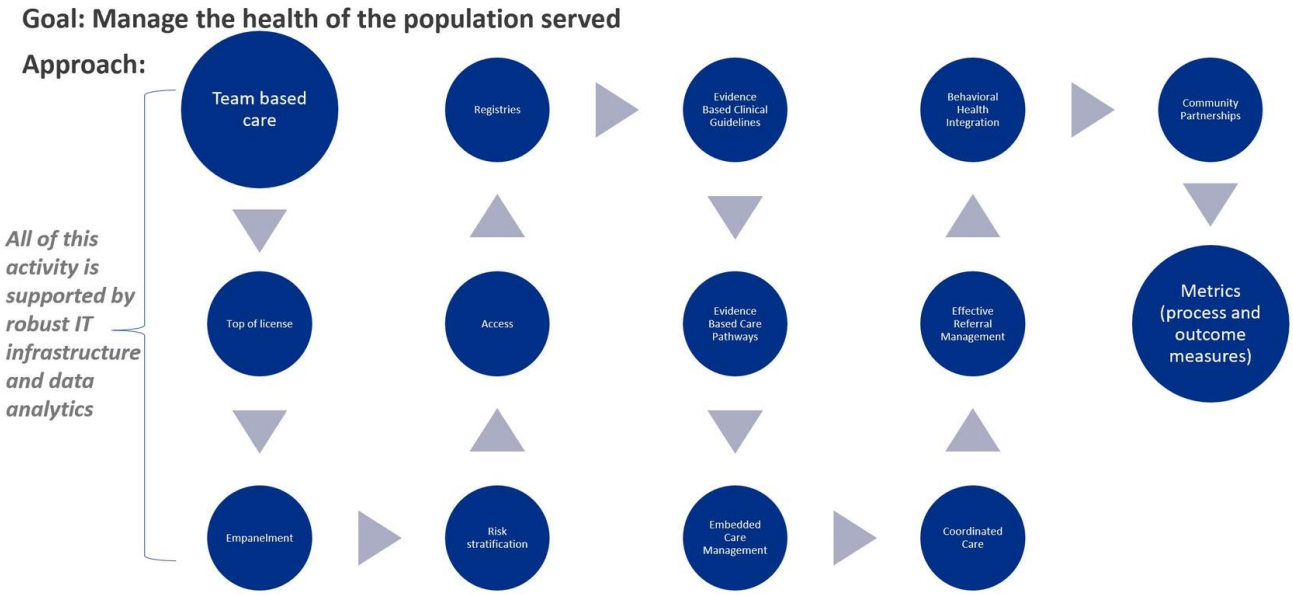
Click to Play Audio

It's important to keep in mind that the approach to management of a population will vary depending upon the perspective of the organization and its goals. The goal of primary care is to manage the health of the population it serves. The focus is on active & empaneled patients attributed to the practice.

The approach will include:

- Implementing a team-based approach to care delivery
- Training staff to work at top of license, knowledge, training, and ability
- Empaneling and risk stratifying the population
- Ensuring appropriate access
- Developing disease registries to track patients with chronic conditions
- Utilizing evidence-based clinical guidelines to standardize the care
- Embedding a care management program
- Establishing collaborative care agreements with specialists and other patients
- Instituting effective protocols for managing referrals

- Establishing metrics to measure the success of population health initiatives



*Note: the above list is not all aspects of a primary care practice's approach to population health management. With so many factors that go into this work, this is merely a representation of SOME of the work to do.

Test Your Knowledge

Question

01/05

Population Health Management addresses all facets that impact the health and outcomes of the individuals within a given population.

- ◯ True
- ◯ False

Question

02/05

What are ways that a care manager can manage the health of the practice population? (Choose all that are correct.)

- [ ] A care manager will monitor the needs of empaneled and risk-stratified patients.
- [ ] A care manager can oversee the care manager/care coordinator team.
- [ ] A care manager can provide services for patients in a high-risk tier.
- [ ] A care manager can monitor processes and elevate issues to the Quality Improvement team.

Question

03/05

Which of the following is an **important** component for measuring the health of a population?

- [ ] Payer claims data
- [ ] A fax machine
- [ ] A mail person/courier to deliver and ship patient data files
- [ ] Enrollment in your local Health Information Exchange
- [ ] Registries

Question

04/05

Which of the following are components of Population Health Management?

- [ ] Behavioral Health Care
- [ ] Clinical care
- [ ] Screening for Social Determinants of Health
- [ ] Monitoring the number of hospitalizations a practice's patients have had

Question

05/05

Every practice/organization must approach population health management in the same way.

- ○ True
- ○ False

Activity Instructions

Practical application of what you are learning helps with skill development and retention. We have created an activity that will guide you in that type of application.

- [ ] Visit https://www.healthteamworks.org/resource/essentials-care-management-activities-and-resources.
- [ ] Find and download the activity assigned for this course.
- [ ] Complete the activity. You are encouraged to work with your team to complete the activity.
- [ ] Email the completed activity to caremanagement_nachc@healthteamworks.org.

- [ ] Make sure to add the Course Activity Title you are submitting and your full name to the Subject Line of your email.
- [ ] You will receive feedback on your completed assignments.