Benefits of Aligning Population Health Management and Value-based Care Goals

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Population health management and value-based care goals have been around for a long time. In 2015, however, the U.S. Congress may have sped up the convergence of these goals by passing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[1]

Out of MACRA came the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (AAPM) programs. These new initiatives effectively phase out three programs — the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBPM) and Meaningful Use of electronic health records (EHRs) — all of which required providers to separately report population health management and value-based quality metrics to the Centers for Medicare and Medicaid Services (CMS).

For CMS, it makes sense to combine elements of the older programs, as they essentially require the same types of quality information (for example, preventive care, chronic condition maintenance, care continuity, etc.). More importantly, though, it should help providers deliver more efficient care by focusing on a single set of standards while improving outcomes among the highest-risk and costliest patients.

Healthcare organizations, including Integrated Delivery Networks (IDNs), are aligning enterprise-wide goals to improve efficiency and clinical outcomes. Supporting coordinated population health management and value-based care programs, however, will likely require healthcare organizations to do more than just revise goals and update workflows — they will need to look at their enterprise as a whole.

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[1] https://www.congress.gov/bill/114th-congress/house-bill/2/text

Benefits of Alignment: Transparent Data, Improved Engagement & Better Outcomes

So, why exactly do you need to align population health management and value-based care goals?

For one, uniting these goals can help healthcare organizations select and optimize the right technology to deliver the data providers need to provide preventive care for patients with chronic conditions. In fact, these patients, whose populations are growing, are responsible for more than 75 percent of annual healthcare costs.[2] As a result, they are usually a top priority of both population health management and value-based care programs.

Strategic alignment of objectives can help you hone in on the most pressing challenges for your organization and patients. For example, facilitating clinical interventions before emergency events occur can help greatly reduce overall costs and improve a patient's quality of care. Yet, such interventions are only possible when you have access to metrics from across the enterprise — especially primary care and specialty clinics — and perform predictive clinical analysis.

Clinical analytics technology supports combined goals by continuously scouring data from care delivery networks and consolidating it for care managers who are monitoring patients. This can lead to better chronic condition management, as well as improved patient engagement.

You are likely aware that patient engagement is a key factor in enhancing outcomes at a lower cost. When patients become more engaged in their care, they tend to follow providers' care plans more closely, including preventive care. As a result, this has been shown to drive down costs while improving quality metrics. For example, if a physician recommends that a patient lose weight and the patient begins leading a more active, healthy lifestyle, they are less likely to be admitted to the hospital for diabetes or weight-related health issues. Engagement also is linked to patient satisfaction, which can improve the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results that are currently linked to roughly 30 percent of a hospital's Medicare payment.

DID YOU KNOW?

$343M **Medicare expects that population health programs will save $343 million over five years.[1]**

The ability to quickly and accurately capture, transform and manage data will likely play a large part in these savings.

1 http://www.investors.com/research/industry-snapshot/can-population-health-management-it-save-ths-federal-budget/

In conjunction, real-time seamless data exchange across the care continuum gives providers the complete and accurate information they need — when they need it — to support more informed care decisions. It's important, though, to make sure to normalize (or "cleanse") data regardless of its format when captured.

For example, assume that an IDN analyzes ICD-10 codes to compile information regarding patients' diagnoses. If a physician enters a diagnosis in SNOMED CT codes, then the organization's technology should automatically map them to the analogous ICD-10 codes.

Clean data will likely become even more crucial going forward, given the increased amount of patient-supplied information outlets that healthcare organizations are beginning to capture from, including:

- Patient portals
- Clinician-prescribed health monitoring devices
- Patient-acquired wellness and fitness devices
- Smartphone apps

[2] http://www.amjmed.com/article/S0002-9343(14)01035-3/fulltext
[3] http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86
[4] http://www.beckershospitalreview.com/finance/hhs-hits-goal-of-shifting-30-of-medicare-payments-to-alternative-models.html

The Cost of Misalignment: High Costs, Data Gaps and Misinformation

The benefits of aligning these goals are clear. Yet, if healthcare organizations don't streamline measures, there could be a slew of repercussions.

Even in the most highly integrated enterprises, providers seldom enter data into the EHR consistently. Consequently, hospitals, health systems and IDNs can end up comparing apples-to-oranges data during analysis activities. This is why the ability to access cleansed data is essential if an enterprise wishes to achieve both population health management and value-based care goals.

Different terminologies or units of measurement can create an unreliable or confusing analysis for merged population health management or value-based care programs. When that happens, providers are left with data that can do more harm than good when used for care decisions. This typically leads to unwarranted clinical variation, which can negatively impact outcomes, as well as increase costs and lower reimbursement under value-based care payment models.

Lack of consistency in data entry or processing can also create data gaps. For example, when a diabetic patient with complications needs to visit the emergency department (ED) while vacationing in a different state, the data from that encounter may never reach the patient's primary care doctor. In addition, the ED staff needs to trust the patient's memory — if he or she is able to communicate — concerning health history and medications, including dosages and most recent administrations.

"These situations can result in undesirable outcomes, driving up costs and reducing clinical quality and reimbursement. In addition, missing data can lead to incorrect trends analyses that end up affecting an entire patient population."

These situations can result in undesirable outcomes, driving up costs and reducing clinical quality and reimbursement. In addition, missing data can lead to incorrect trends analyses that end up affecting an entire patient population. Inaccurate trend analysis can lead to oversights and worsening conditions among populations, which is likely to result in diminished quality performance and surging costs.

From a productivity perspective, missing, inaccurate or outdated data can increase the amount of time providers spend searching for reliable information. It can also lead to incorrect financial forecasts and errors. As a result, this can reduce productivity and negatively impact all areas of the care continuum.

DID YOU KNOW?

60% of c-suite executives plan to up 2016 budgets for population health/ new payment initiatives.[1]

One way to do this is by investing in tools to properly capture, manage and transform information.

1 http://www.fiercehealthfinance.com/story/hospital-systems-continue-investments-population-health/2015-11-01

A Real-world View of What Alignment Looks Like

Aligning value-based care and population health management goals can help you achieve a holistic view of your patients' physical and mental health conditions.

Achieving a well-rounded view of your patient's health can be especially helpful when confronting organizational challenges such as patients who misuse the ED. In many cases, ED "frequent flyers" face not only clinical, but also psychosocial conditions that require the help of behavioral health specialists or community organizations.

Technology in an aligned organization could alert the attending physician of a patient's ED visit frequency, as well as present data from the patient's primary care and behavioral health team to support decision making. Through fast and accurate discharge reporting, the patient's care team would know that the patient had again visited the ED and would be able to schedule follow-up visits with the appropriate clinicians.

In addition, before a patient arrives in the ED, monitoring and analytics technologies could help alert care managers identify a potentially high-risk situation. This then enables care managers to perform an outreach call to resolve any issues over the phone before matters become worse.

Take the following patient-care scenario below for example, it illustrates how aligning goals and systems can improve patient care and efficiency:

A 67-year-old man with coronary artery disease schedules hernia repair surgery at a hospital where he has received care several times. The patient's office-based primary care physician and surgeon have cleared him for surgery, so he is fasting when he arrives at the hospital for the procedure. On arrival, however, the admitting staff lacks the results from his most recent EKG, which they request from his cardiologist's office. After waiting two hours, staff finally inform the now hungry and anxious patient that the EKG results have been faxed and it's time for surgery.

The long wait and lack of preparedness is likely to frustrate the patient and could change his opinion about the hospital's care quality. Furthermore, delaying a surgery by two hours disrupts the surgical suite's entire schedule, adding to costs for the hospital and providers while potentially leading to cancellations and lost revenue.

Connecting systems and data across this enterprise's inpatient and outpatient facilities, and even with unaffiliated practices, could have helped improve communication between providers as well as between providers and patients. The result: delays and frustration could have been eliminated and the patient could have returned home with higher level of satisfaction with his providers.

Likewise, it's also important to take actions to help patients receive the post-discharge instructions they need — and in the format they need them — when they return home. That might mean accessibility through a mobile device, for example.

Do this sound similar to situations your organization has encountered?

The good thing is there are relatively simple steps you can take to start aligning your goals for long-term success.

5 Simple Steps to Get You on the Track to Population Health Management and Value-based Care Alignment

Merging your population health management and value-based care goals is highly attainable even without major infrastructure changes. The following considerations and questions can help you begin the journey toward alignment of your healthcare organization:

1 Assess

How is your organization currently pursuing its population health management and value-based care goals? Where are the overlaps in terms of processes and data analysis? Aligning these initiatives and combining collected data to assess performance on both goal sets could help save time and resources.

2 Integration

How well are EHRs, data storage systems and communications systems integrated in your inpatient and outpatient facilities? What is the delay between when a patient is discharged from a hospital to when primary care and other office-based physicians receive discharge information to support care coordination? Enabling the real-time or near real-time flow of information is possible with fully integrated systems.

3 Access

How simple is it for providers to access and interpret data, regardless of its origin? It helps for data to be comprehensive, but also easy to understand and obtain to support prompt evidence-based decision making. This can apply to providers at the point-of-care, as well as care managers monitoring patient populations and financial analysts watching spending.

DID YOU KNOW?

59% of healthcare decision makers cited the high cost of healthcare as the reason for their interest in business models that facilitate value-based care.[1]

To lower costs, implement solutions that enable you to capture, transform and manage information when and where you need it.

1 http://health-information.advanceweb.com/Features/Articles/Healthcare-Embraces-the-Big-Data-Explosion.aspx

4 Accuracy

How is the organization confirming that data is reliable? Safe and effective care, for a population or individual patient, requires complete and accurate data. Trust in data means that physicians might be less likely to repeatedly order expensive tests or less effective medications, reducing the overall cost of care for the organization.

5 Security

What measures are in place to securely share information with patients, payers and other providers? Preventing breaches of protected health information is a significant cost and quality issue that can also severely impact an enterprise's reputation and effectiveness.

Preparing for a Data-focused Healthcare Environment

Population health management and value-based care programs can benefit from working together. CMS, MIPS and AAPM programs are proof of the industry evolution toward goal alignment. Healthcare organizations including IDNs can expect that CMS, commercial payers and other stakeholders will continue to drive initiatives like these that emphasize cost-effective preventive care — with a focus on patients with chronic conditions — for decades to come.

Aligning population health management and value-based care programs also requires information systems and workflows to be in sync, so that complete and accurate data is available to providers and financial analysts when and where they need it. Information mobility — the ability to securely capture, access and transform information — can help organizations eliminate the bottlenecks and silos that exist today and promote clean data access to providers, financial staff and patients.

Identifying obstacles, streamlining communications and building collaborative, data-driven practices offers focus for healthcare organizations. That focus can help break through the physical walls of inpatient and outpatient facilities so organizations can effectively manage the health of patient populations and achieve value-based care. Combined, these objectives can help improve patient outcomes and help healthcare organizations thrive in an increasingly data-focused healthcare ecosystem.

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