



Population Health Strategies for Success in a Value-based Care Environment

As healthcare organizations embrace value-based care, the goals become improved outcomes and reduced costs. Population health programs are offering a means to this end, but challenges loom. A recent survey conducted by HIMSS Media sheds light on the specifics of these challenges, while one physician practice's population health journey, presented at HIMSS18, in Las Vegas in March 2018, illustrates how healthcare organizations can actually navigate through challenges and succeed.

According to the survey of 96 clinical, business and IT professionals, the top three population health challenges for independent ambulatory healthcare organizations consist of ensuring gaps in care are closed during the visit (51 percent); efficiently and effectively managing outreach to priority cohorts prior to or after the patient visit (39 percent); and efficiently and effectively coordinating team-based care on the day of the patient visit (39 percent). For integrated delivery networks (IDNs), bubbling to the top of the list of challenges are ensuring the medical record reflects all population health activities (46 percent); efficiently and effectively managing outreach to priority cohorts prior to or after the patient visit (43 percent); and identifying patients in need of intervention (41 percent).

To move population health along, independent ambulatory healthcare organizations and IDNs are focusing on reporting/quality tracking (71 percent), care coordination (68 percent) and care management (68 percent). "Healthcare organizations identify different challenges, but when it comes to the broad steps that they're taking to address population health, they're all focusing on those three things," said Janet King, Senior Director of Market Insights for HIMSS Media.

To move population health along:



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L A Civitarese, DO, MMI | Preferred Primary Care Physicians

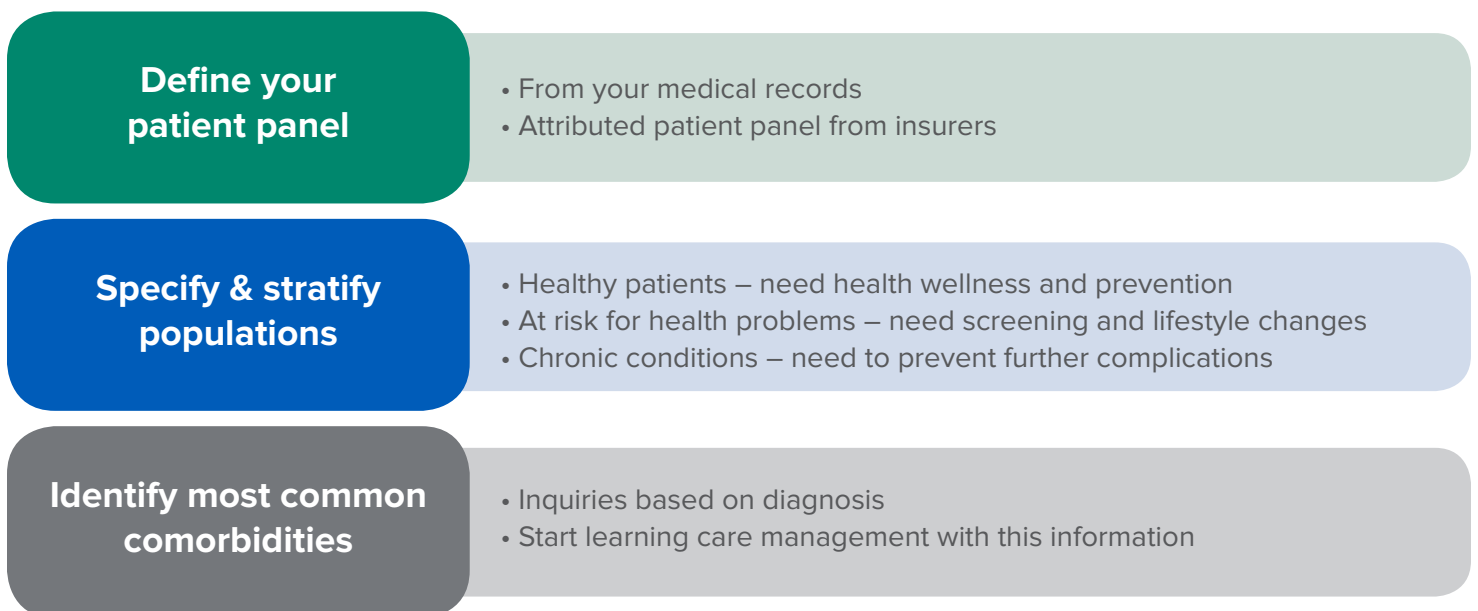
On the path to success

Meeting the challenges associated with population health has become a top priority for Preferred Primary Care Physicians, as the 60-provider single specialty group is keenly focused on succeeding under value-based reimbursement models. “In our enterprise, we can’t look at primary care as being a loss leader. We don’t own an imaging center; we don’t own an ambulatory surgery center; so, we are now dependent on pay per value,” said L A Civitarese, DO, MMI, one of the practice’s leaders.

As such, the group is relying on population health programs to experience coveted outcomes improvements and cost savings. As the practice traverses this path, leaders have discovered that it is imperative to define patient populations (Figure 1). Understanding the patient population helps to stratify populations into various groups such as healthy patients who need wellness and prevention services; at-risk for health problems patients who need screening and lifestyle changes; and those with common morbidities who need chronic care management.

Defining populations is just the beginning. Preferred also zeros in on working with the patients who are most likely to benefit from proactive interventions. “We try to be disciplined and ask ourselves which patients we can truly impact, instead of wasting resources by including all populations,” Civitarese pointed out. For example, “cancer care right now in our part of the world is something that is very difficult for us to impact. We’ve recognized that this is something that we are not going to make a lot of progress on at this time. So, we can’t afford to direct our global resources toward oncology,” he added.

Figure 1: **Who Are Your Patients?**



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L A Civitarese, DO, MMI

Instead, the practice focuses its efforts on populations where a significant return on investment can be realized — and then quickly engages these patients. “Once we identify a core population, such as diabetics, we introduce them to the care management team, allow them face-to-face communication initially, and then offer electronic, telephonic communication to develop trust and rapport,” Civitarese said. “One of the big reasons for our success is that [we have learned that] every medical assistant, every care manager, every physician [can play a part] in patient engagement. In our mind, this is where population health happens.”

Establishing these connections with patients is important as the medical practice emphasizes shared decision-making. “If I walk into a room and tell the patient that they need three immunizations, a colonoscopy and multiple other measures, I need to understand that they might have

legitimate fears and may not agree with that,” Civitarese said. A collaborative approach, however, “demonstrates to our patients that we respect that it’s ultimately their decision, and ... if they need six care gaps closed, I am willing to compromise and get two of them closed that day. I’ll deal with the next gaps a few months later,” he said. Creating such trust helps to continually move patients toward better health.

Patient	Data Source	DOB (age)	Coordinator	Appointment	Workflow State	Breast CA	Cervical CA	Colon CA	Anxiety	Depression Screen	Call Patient	Review/Update Care Plan	Review Care Gaps	Perform Assessment	Review Preventive Services	Review Next Visit Agenda	Coordinate Care	Other Action	Bill Complex CDM	Total Time	OK to Bill	
Adams, Alice	GE	1/1/1950 (68)	Lynn Marks		Due For Call	Due	Due	Due	Due	Due	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m
Allen, Debbie	GE	12/1/1950 (57)	Lynn Marks		Due For Call	Due	Due	Due	Due	Due	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m
Anderson, Lucille	GE	3/7/1954 (64)	Lynn Marks		Waiting for provider response	Due	Due	Due	Due	Due	5 m	10 m	5 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	20 m	5 m
Bassett, Donald	GE	1/1/1950 (68)	Sean		Active Enrollment	Due	Due	Due	Due	Due	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m
Bouchard, Jessica	GE	4/30/1950 (57)	Lynn Marks		New Patient	Due	Due	Due	Due	Due	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m
Bruce, Miss	GE	1/6/1958 (30)	Lynn Marks		Active Enrollment	Due	Due	Due	Due	Due	5 m	5 m	5 m	0 m	0 m	0 m	0 m	0 m	0 m	0 m	15 m	5 m

GE Healthcare’s Ambulatory Population Health module includes a role-based care coordination workflow tool that helps teams collaborate and optimize the value of care delivered.

Data analysis, however, is key to succeeding on a broader population level. For example, while it is important for care managers to meet with diabetic patients to assess blood sugar levels, diet and medication compliance on an individual basis, an analysis of aggregate data can help the practice prioritize efforts by identifying and closing various care gaps related to who did or did not receive pneumonia or flu vaccines, angiotensin-converting-enzyme (ACE) inhibitors or statins. “Organizations have to start with the data that they have, whatever that may be,” Civitarese said. Population health management solutions, however, can help.

To this end, Preferred had developed its own point-of-care population health tool. “But we had to make a strategic and somewhat emotional decision a couple of years ago and decided that it just wasn’t feasible for us to keep up with the ever-changing evidence-based medicine guidelines,” Civitarese said.

As a result, the medical group set out to find a solution that offered the capability to support data aggregation, risk stratification, care coordination and patient engagement. While doing so, however, practice leaders made a concerted effort to find a solution that would meet the specific needs of the group. “We don’t have the same needs as an academic medical center. That’s not who we are. We are a single specialty primary care group. So, we had to have the discipline to make sure that we didn’t try to ‘keep up with the Joneses,’” he said.



It's time for your **Hepatitis B** immunization

*One primary care office realized a **425%** increase and another a **764%** increase in **Hepatitis B** immunization revenue by providing a reminder to physicians when patients were appropriate candidates for the vaccine.*



The group implemented the Ambulatory Population Health module, which integrates with their electronic medical record from GE Healthcare. The integration makes it possible for clinicians to utilize data and evidence-based guidelines to make point-of-care decisions both during and between office visits.

“Whether it’s health maintenance issues, diabetes specific or cardiovascular specific, in a glance, I can see my ‘opportunities.’ All I need to do is confirm that I agree with the recommendations and then have the discussion with the patient, answer their questions, and the patient and I mutually decide which of those gaps we’re actually going to close,” Civitarese said. The tool also helps care managers identify and close care gaps. For example, the dashboard might indicate which diabetic patients have not had an office visit for several months, prompting the care manager to schedule appointments.

With these population health capabilities in place, Preferred has quickly closed several care gaps. For example, just six months after implementing the capabilities, one primary care office realized a 425 percent increase and another a 764 percent increase in Hepatitis B immunization revenue by providing a reminder to physicians when patients were appropriate candidates for the vaccine. The group also improved its quality scores with one of its payers by moving from providing statins to 62 percent of diabetic patients in the first quarter of 2017 to 81 percent of diabetic patients in the fourth quarter of 2017.

The population health capabilities also have prompted clinicians to more routinely administer immunochemical fecal occult blood tests (IFOBT) with patients who refuse colonoscopies. The practice performed 11,226 of these tests between August of 2016 and January of 2018 — which led to colonoscopy follow-ups for 489 of these patients and the identification of cancer in 15 of them.

“If we didn’t have the population health tool in place, we would have missed 12 of 15 cancer diagnoses. That’s pretty staggering,” Civitarese said. Indeed, such results have certainly put the organization in the position to do what it set out to do — achieve the improved outcomes and reduced costs necessary to succeed under value-based models.



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