starting small with population health management

Healthcare organizations can ensure they are prepared for the inevitable proliferation of payment models focused on population health management by developing and implementing corresponding strategies in small pieces.

As a result, many organizations face a critical decision: Invest in transformation efforts that position the organization for future success, or delay investment in population health management in favor of other funding priorities.

For most organizations, the answer is straightforward: Start now, and start small. Health systems of all sizes should start driving incremental change now to best position themselves for the inevitable transition to population-health-focused payment models. Three initial, complementary steps, outlined below, can create momentum for increased and ongoing transformation while requiring limited investment in infrastructure and resources.

**Develop a Population Health Strategy That Is Comprehensive**

An actionable strategy cannot be pursued without a clear understanding of how the organization can best progress from its current state to the desired one. By defining the direction it should take in its care delivery transformation, a health system can gain a basis for embarking on a gradual, phased approach to implementation. The organization should begin this effort by thoroughly assessing its readiness for population health initiatives.

**AT A GLANCE**

The efforts of hospitals and health systems to prepare for payment models that reward effective population health management should begin with three broad steps:

- Develop a comprehensive population health strategy
- Build a culture of performance improvement
- Optimize primary care teams
evaluating the following six organizational elements, in particular.

**Provider network.** To be able to effectively manage the health of its patient population, an organization requires a provider network that is of sufficient size and scope to deliver care across the continuum. Under value-based models, such as bundled payments or shared savings arrangements, organizations assume financial risk for patients across multiple settings, including ambulatory, hospital, and post-acute care. Strong coordination and alignment is critical to effectively plan for and manage the greater risk inherent in this approach to care.

**Provider compensation.** As payment arrangements lean increasingly toward value, provider compensation should reflect the shift. In traditional compensation models, under which providers are compensated solely on production of work relative-value units, providers lack adequate incentives to spend additional time with patients, provide education, and conduct patient outreach. Health systems can promote their population health efforts by developing provider compensation plans that reward physicians for meeting specific cost and quality measures.

**Payment models.** Health systems should pursue effective payment arrangements with health plans that support care transformation. Such value-based payment models will provide incentives for proactive patient management. Moving away from fee-for-service payments to such payments also can enable health systems to be more flexible in investing in resources and infrastructure that support population health efforts.

**Care models.** Although changing compensation and payment models is an important means to enable providers to deliver population-focused health care, such actions do not address the processes that determine how patients seek care. Effective and efficient care models promote coordinated care across the continuum, with initiatives focused on managing patients who are at highest risk for poor outcomes and/or high utilization. Under traditional models of care, providers wait for patients to present themselves at the practice and then deliver needed care within the physical confines of the healthcare delivery site. If patients are seeking care at multiple locations, it falls upon the patient to ensure that their regular care provider is receiving all pertinent information. Under a population-centric care model, all care is coordinated through the patient’s clinical care team, usually consisting of a primary care provider and supporting staff such as nurses and care managers. Higher-risk patients may receive additional services, such as care management services, to ensure patients have the support they need to follow through on necessary care.

**Clinical informatics.** Health systems are under intensifying pressure to develop high-performing provider organizations and integrate clinical services across the care continuum. Sophisticated informatics support the transformation of care models by allowing organizations to understand the highest-risk populations and by reporting the quality and cost outcomes of care delivery.

**Organizational foundation.** Transforming care models requires a strong organizational foundation, with leaders who are committed to establishing stakeholder buy-in and developing a culture of continuous improvement and accountability. Without these, an organization will be unable to achieve or sustain its population health management goals. Establishing this foundation may require adding key competencies to an existing management structure. For example, data analytics capabilities, the ability to manage change processes, and the ability to encourage
patient engagement are all valuable competencies for succeeding under population health. Installing these competencies may necessitate the hiring of new positions (e.g., chief population health officer, chief transformation officer) or creating new methods for executives to collaborate on initiatives (e.g., creating a population health advisory committee on which finance leaders, physician leaders, and IT leaders jointly make decisions regarding population health initiatives and investments). In addition, it is crucial that the organization has strong physician leadership capable of championing the shift to greater value-based care delivery.

A comprehensive and objective assessment of each of these requisite elements can give a health system a holistic understanding of its level of maturity for a population health initiative and its relative ability to achieve its care delivery goals. The exhibit above highlights the characteristics of organizations at varying stages of evolution toward a population health model.

In many cases, organizations find that they are highly developed within certain areas of readiness but relatively undeveloped in other areas. Consider the following case example:

An integrated health system developed work groups to pilot various transformation initiatives as part of the organization’s effort to transition to a population health model, only to find that poor coordination among work groups was undermining the effort. Each group was defining its own investment needs, yet leadership had no way to discern which investments were critical. Moreover,
leaders’ attempts to establish priorities among competing needs raised an additional challenge of determining how to pace the transition to a population health model.

On assessing its overall readiness for population health management, the health system found that it was most advanced in the area of care models, having developed multiple care model initiatives, but the highly evolved governance structure required to guide its population health management initiatives was lacking. It also lacked the informatics required to identify which programs were successful and should be scaled across the organization. The readiness assessment provided the health system with the insights it needed to develop and execute a focused and practical three-year strategy (as detailed in the exhibit above) for transitioning to a population health management model.

**Build a Culture of Performance Improvement Within Ambulatory Practices**

True transformation requires a change in culture, not merely a change in processes. And both the time and resources required to achieve a cultural shift should not be underestimated. To successfully transform a culture, change must be incremental and occur in phases, and the process requires a strong leadership commitment and often a significant amount of time.a One critical step for engaging ambulatory practice staff in transformation efforts is to build a culture of performance improvement within those practices. Doing so may offer the following benefits:

- Help staff to become comfortable with process change
- Create a culture of excellence and constant improvement

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> Make it easier to correct course when initiatives do not produce desired changes in performance
> Promote a team-based culture within practices

Many methodologies exist for performance improvement, but the process in all cases can be distilled down to three basic steps: analyzing data, piloting methods designed to realize improvements in the data, and then evaluating the effects of implementing those methods.

A major challenge of instituting performance improvement, however, is the time and effort required to collect and report data. Multiple governmental initiatives (e.g., electronic health records [EHR] incentive program, with its focus on meaningful use, and the Physician Quality Reporting System [PQRS], both administered by the Centers for Medicare & Medicaid Services) require reporting of quality and/or cost metrics. In fact, a recent study found that the United States spends more than $15 billion and 785 physician hours annually to report on metrics.\(^{b}\)

Fortunately, because so many resources dedicated to reporting on performance metrics already are available, ambulatory care practices are well prepared to utilize those metrics to develop performance improvement capabilities. Initial metrics need not encompass all measures the organization eventually will want to track. Again, the idea is to start small. Approaching performance improvement incrementally will help build the momentum practices need to create successful and scalable processes to implement across the organization. The following case example demonstrates this point:

Early in the process of transitioning to population health management, a health system decided to create an inventory of all metrics it was currently collecting for PQRS, grant programs, and a pay-for-performance payer contract (as shown in the exhibit on page 6). The organization found that two metrics were being reported for at least three of the four programs, although a formal process of analyzing data and implementing methods to improve metrics did not yet exist. Because all of its clinics were reporting these two metrics, the health system decided that the best way to develop a performance improvement structure for all clinics—and avoid overwhelming its IT and reporting staff—would be to focus the efforts on only the two metrics. Removing the burden on staff of a focus on more comprehensive reporting enabled practice leadership also to implement formal training for staff in quality improvement methodologies.

Provider buy-in is an important consideration in selecting metrics, especially for organizations that have issues with data reporting from their EHR and receive complaints about the validity of data. To mitigate provider pushback, a health system should consider holding off on reporting performance metrics at the provider and/or staff level until any reporting issues have been resolved. Tracking performance metrics at the practice level will ensure that improvement efforts focus on changes in processes rather than on the practice choices of specific individuals.

Optimize Teams Within Primary Care
Primary care serves as the lynchpin for population health management. Unfortunately, primary care providers often do not feel they have the resources to deliver on the growing expectations of patients and health systems, which include increasingly convenient care and more robust patient-provider relationships. One result is physician burnout, reported to affect nearly half

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To combat burnout, primary care experts recommend that a fourth aim be added to the Triple Aim of improving the patient experience of care, improving the health of populations, and reducing per capita cost—improving the work life of healthcare providers. This new “quadruple aim” can be best achieved by developing high-functioning teams within primary care to reduce the burden on primary care providers. Several studies have shown that even nonclinical staff can play a key role in carrying out many of the activities that need to occur with a patient-centered care model.

At Kaiser Southern California, for example, medical assistants review care gaps in the patient’s record and can place orders to fill care gaps based on protocols. This practice has allowed the health system to improve outcomes, including timeliness of diabetes care and cancer screenings.

A study of patient-centered medical homes within the Veterans Health Administration found that front-office staff served a vital role in collecting patient information and communicating it to the rest of the care team. Care teams were better informed about patient preferences and socio-economic and demographic determinants of health care, which also contributed to improved patient satisfaction.

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Creating high-performing primary care teams does not necessarily mean making big changes to staffing. In fact, the opposite is often true. By optimizing each team member’s role and eliminating inefficiencies, systems can attain peak performance without additional staff. Applying the following four steps can help practices maximize team contributions and overall performance.

Map all tasks that need to happen before, during, and after a patient visit. These tasks may include, for example, answering patient calls, notifying patients of normal lab results, taking vitals, reconciling medications, conducting patient education, and following up with patients after a hospitalization.

Identify who currently performs each role. It is critical that front-line staff be involved in this conversation. During this process, it may be found that many tasks are being performed inefficiently or do not need to be performed at all. Examples include writing down phone messages when patients call, rather than resolving the issue over the phone, or requiring patients to check in multiple times for their appointments. Identifying and reducing such inefficiencies can help free time for team members to perform more essential tasks.

Determine who should perform each role. Tasks should be assigned based on licensure, skill level, and practicality. In a high-performing practice, all staff should be practicing at the top of their license to ensure that each task is being carried out as cost-effectively as possible. For example, nurses should spend most of their time performing tasks that require a nursing degree.

Redesign workflows as needed. Workflows should be adapted to close gaps and eliminate duplication, ensure equitable workload balance, and create patient-friendly processes. As in any transformation effort, workflows should be tested and evaluated within one care team before being scaled across multiple practices.

Although additional staff may be necessary to perform tasks such as providing care management for patients, optimizing existing roles is an important first step toward increasing efficiency within a practice and reducing the burden on providers.

Small Steps, Big Changes
Population health management is far too big a challenge to take on all at once. But it also is an effort that should not be put off. Health systems that wait to transform care delivery until they no longer have a choice will find themselves in an uncomfortable and untenable position. Forward-thinking organizations, on the other hand, will recognize the opportunity to make small and achievable steps toward population health management meaningfully and sustainably. By starting with these three basic steps—developing a population health strategy, creating a culture of continuous performance improvement, and optimizing primary care teams—health systems can better position their organizations to achieve the essential goal of value-based care: delivering care in a way that helps improve and sustain the health of their overall patient populations.

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