Why is Everyone Talking about Population Health?

Bruce Bagley – April 9, 2014

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Why the sudden interest in population health when the ability to segment and design specific approaches to subgroups of patients has been around for years? Right now, "population health management" is code for…you better identify the high cost patients and do something about it! With the increase of risk sharing arrangements, integrated systems and fledgling accountable care organizations, business leaders are looking for ways to better manage their most expensive patients. It is fairly well accepted that 3% of the patients in any large claims database generate about 30% of the total medical spend, and the top 10% of patients by expenditure puts the proportion of total medical spend cleanly over 50%. With that fact as a backdrop, early efforts at population health with a goal to rein in costs must focus on the top 5% to 7% of the patients in any primary care practice panel. Although there are very good reasons to risk stratify the entire patient population, if saving money is what you are trying to accomplish, most of the heavy lifting has to be in this subset of patients. Fortunately, for those of us who are professionally motivated to serve patients one at a time, these are the very same people who need the most help. So the question becomes - how do we identify this group and restructure our care to achieve both goals?

Risk stratified care management and care coordination are the keys to success. The meaning of the word "risk" in this context is the likelihood that a patient needs extra help in managing his or her chronic illness and/or help in navigating the complex and often fragmented medical neighborhood. Primary care practices must have a way to segment the patient population into groups, so that specific effective approaches can be implemented for each group.

Many algorithms have been derived, but they all should make some sense to the clinicians who are using them, and clearly identify the people who need the help. For a nice presentation of the conceptual framework that should underpin any population management effort, see "Risk Stratified Care Management" at www.aafp.org/rscm Regardless of how many categories your algorithm uses, it must identify two important groups - those in need of extra attention because of the disease burden from multiple chronic conditions, advanced age or cognitive impairment; and those who are appropriate candidates for palliative or hospice care at the end of life and clearly need a different set of services and support. Computer generated lists can help but there must be clinical input to identify patients who are likely to become high risk over time.

Some practices use algorithms that result in too many patients being designated as high risk, and cannot muster the resources to actively manage them all. Keep in mind that the precision with which you assign the risk category is not as important as your game plan for what you will do after they are assigned.

Here is what you will need to do this work well:

1. A simple algorithm to identify at least these two groups

2. An individualized and detailed care plan that all can understand and that travels with the patient from one point of care to another

3. A registry function (ideally embedded in the EMR) to reliably track each patient, monitor progress and support outreach efforts

4. An explicit game plan or approach for how clinicians with the rest of the care team will accomplish this work, and who will be responsible for maintaining the system

5. Service agreements with community resources such as hospitals, subspecialists, the VNA, home care and hospice

6. Care team members may need additional training in population health management

Once the practice has RSCM working well for the high risk categories, then it can move on to similar but often less intensive work for the lower risk categories. Although it may take some resources and time to get this up and running, once it is embedded in the workflow it should be just part of the care you provide for these complex patients.

I am certain that someone will want to know where the money, time and staff are going to come from to support this work. If ACOs or integrated systems are going to lean on primary care practices to help reduce the total cost of care, there must be an acknowledgement that it requires some infrastructure support. As a transition strategy, care management fees have helped to support this work but ultimately it must be built in to the system and considered as an essential tool for providing great care for all.

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