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Population Health

3 key questions for pop health success

Jonathan Scholl, president of Leidos Health advises CIOs to ask and answer three key questions.

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As the U.S. healthcare system continues on its march from volume to value-based payment, providers are experimenting with myriad new programs designed to share financial risk, assume capitation contracts, generate reimbursement for outcomes and avoid costly penalties. The basic idea: In the not-so-distant future, hospitals will no longer be paid for what they do, but for what they don't have to do.

"Value-based care flips the entire current American hospital model on its head," said Robert Havasy, senior director of health information systems at HIMSS. "Everything that was a cost becomes potential revenue, and everything that was revenue becomes a cost to be controlled. ... Expensive hospital utilization becomes a cost that you want to reduce."

According to HIMSS Analytics, population health management programs are among the most attractive initiatives in this new paradigm, with more than three-quarters of all hospitals launching a PHM, or pop health, initiative by the end of 2017. By identifying and segmenting specific populations of patients, stratifying risk and improving their health status to avoid more costly interventions, these programs promise to improve both clinical and financial outcomes.

However, Jonathan Scholl, president of Leidos Health, has seen many organizations struggle with their PHM initiatives. The problem, he suggests, isn't with data tools and technology. Instead, it is that too many hospitals race to "improve" outcomes before they fully understand the challenges they face. In order to derive ROI from pop health, organizations need to clearly define their objectives.

Scholl advises CIOs to ask and answer three key questions:

1. ***What population, exactly, do you intend to address?***
   A city's public health agency might define its population as all residents. A practice in suburban Virginia might focus on a Medicare Advantage population. Said Scholl: "Step 1 is to answer that question specifically. It defines the degrees of freedom — all your subsequent choices — in designing a PHM program."
2. ***What is "health" for that population?***
   "'Health' is the second term in need of definition," he said. "A very common mistake we see organizations make is 'ready, shoot, aim.' They gather a bunch of data, create visualizations and dashboards, possibly model and stratify risk, and distribute them to clinicians and caregivers with the charge to improve. Sometimes they even appoint administrators to track progress. But, is this actionable? Defining 'health' has to go beyond quality measures and become evidentiary, which is where physicians would like to see it taken. Are we, for instance, following the best evidence-based practices for managing a population of diabetics?"
3. ***What do you intend to manage?***
   To achieve health outcomes, manage the actions you control. "By providing caregivers and clinicians with the ability to access the right data sets, we believe the future will be more about managing patients with high efficiencies and low variable workflows that will deliver a deeper understanding of the individual patient as well as member segments that add up to their 'population,' resulting in lower costs and higher profitability," Scholl said.

Of course, there's a fourth question at the heart of any PHM initiative — how will you be paid? It's critical to understand how the initiative generates revenue. Value-based programs within MACRA (Medicare Access and CHIP Reauthorization Act of 2015), MIPS (Merit-based Incentive Payment System), or MSSP (Medicare Shared Savings Program) are good places to start, he said.

"In the end, population health is enabled by a financial system that rewards you for value," said Scholl. "For health systems to invest to make a population healthier, what's in it for them if they don't participate in a financial model that rewards them for doing it?"

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