

Putting Population Health Strategies to Work

A new health care paradigm is upon us, don't wait to change your business model.

BY SUZETTE JASKIE

A new health care lexicon has emerged during the past several years. Accountable care, value-based care, care bundles, clinical integration, and population health now dominate the health care landscape headlines. But when asking programs about their population health strategy, the typical answer is something to the effect of, "We don't have any (population-based) contracts in our market yet," or "We're waiting for 'the (hospital) system' to determine what our population health strategy is." The result has been little progress in the understanding and pursuit of population health strategies.

POPULATION HEALTH AS A TRANSFORMATIONAL DELIVERY MODEL

The aim of population health is to provide high-value care to patient populations, with reliable, consistent, and transparent quality outcomes measured at the population level. A primary tenet of population health is the provision of services across the care continuum—a comprehensive or almost holistic approach in which programs purposely knit together distinct services, including prescribed transitional care. Because cardiovascular services are routinely delivered to patients in both ambulatory and facility settings, they are among the best suited to pursue population-based strategies. Although there are excellent examples of programs succeeding at providing cardiovascular care more holistically, the real gains promised by this approach have not yet been realized.

Cardiovascular programs have been largely built around ischemic heart disease and related procedures. The procedural focus, together with the increased training requirements to provide these procedures, has fostered the development of cardiologist subspecialization. Cardiovascular service lines typically provide four or more subspecialized services: intervention, imaging, electrophysiology, and now,

heart failure and structural heart disease therapy. One of the consequences of procedural and subspecialized programs, which provide increasingly better care and options for patients, is care fragmentation—a primary problem that today's reforms aim to correct. The belief is that quality will be improved, and costs will be reduced if delivery systems transition to population-based delivery. Some of the typical features of a population-based clinical strategy include:

- Coordinated, full-care continuum—physician, staff, and other resources deployed consistently and purposefully to patients with similar conditions
- Adherence to agreed upon clinical standards, protocols, and pathways
- Utilization and patient-selection metrics
- Predictable, high-value care delivery with measured outcomes
- Success defined by outcomes that matter to patients
- Clinical and cost performance transparency

These and other population-based program features are detailed in Figure 1, which illustrates a full-care continuum delivery model, the distinct stages, and clinical activities involved in each stage.

POPULATION HEALTH VERSUS FEE-FOR-SERVICE DELIVERY SYSTEM

By nature, population health strategies require integration, collaboration, and consistency in the approach to patients. A population-based strategy would require providers to work systematically and redefine the meaning of group practice. Traditionally, cardiology practices could be described as individual cardiologists and their practices sharing call and overhead expenses. In a population-based delivery approach, the practice takes a team approach to care, embracing subspecialization and sharing patients in prescribed ways based on consensus-based pathways.

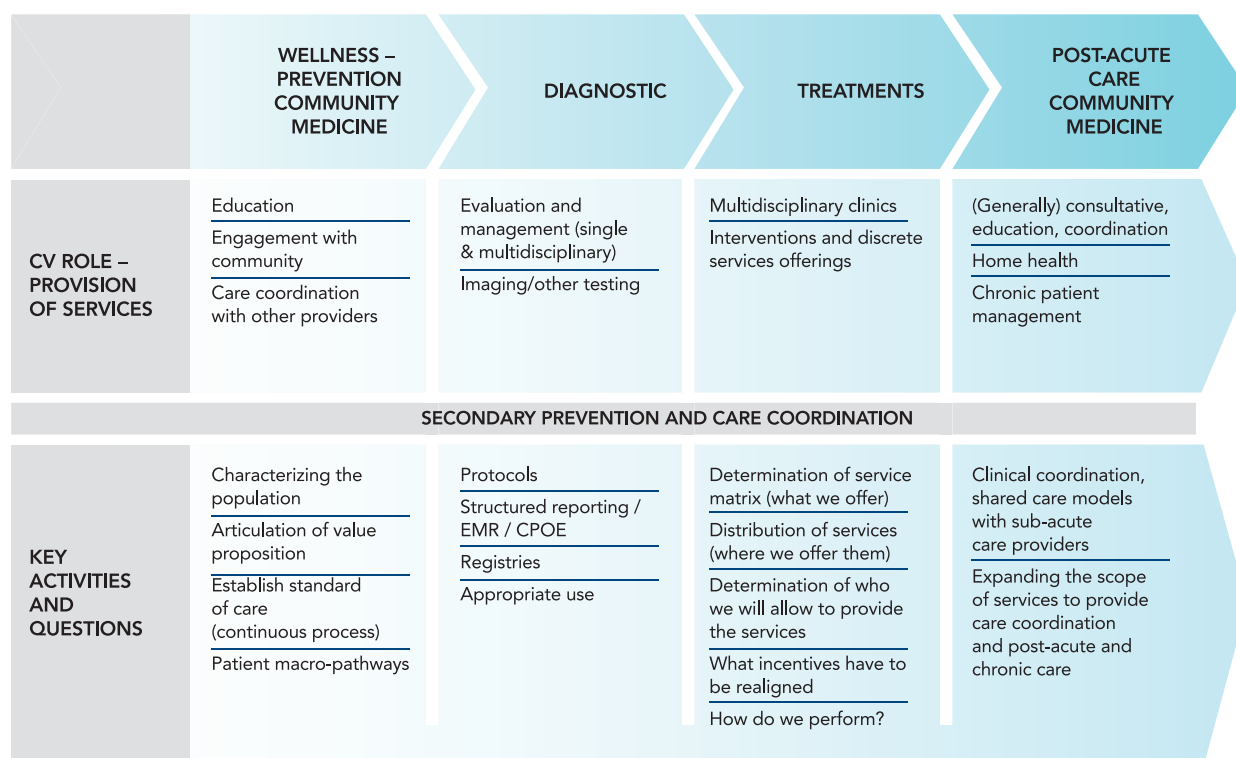


Figure 1. A population-based clinical program.

Population health requires consistent adherence to care standards supported by electronic medical records and frugal utilization of resources, regardless of perceived unit-calculated margins. It takes the practice of medicine from an individual sport to a team sport and is an enormous shift in the health care delivery paradigm. With the understanding that population health requires a fundamental change in the mindset of the physicians and reorganization of day-to-day operations, the slow pursuit becomes more reasonable. Certainly, population-based strategies cannot be achieved by a hospital system without the physician's shift in thinking and engagement in the belief that this is a better way to care for patients.

One example of successful population-based strategies being deployed in programs today is in re-envisioning the concepts of centers of excellence. Many programs have started their population health journey by embracing subspecialization and creating "centers of excellence" sites focused on specific disease states. Physicians who have expertise in treating a certain patient population (eg, those with heart failure or atrial fibrillation) are empowered to determine the appropriate care standards using evidenced-based medicine and interdisciplinary consensus, which is disseminated throughout the system.

Another example is purposeful staffing deployment. This means utilization of care teams led by physicians and composed of licensed and unlicensed staff designed so that all team members are working at the top of their license and delivering care based on agreed protocols, pathways, and

care objectives. Care teams provide value by reducing costs, increasing access to care, and utilizing physicians focused on diagnosis, treatment, and care determination for patients.

Enhancing transition care is yet another strategy for population-based health. Many programs have recognized that gaps in care quality often occur during the transition of patients between care sites or providers. Enhanced transition care aims to purposefully connect patients to longitudinal care plans, regardless of the location or provider. Such innovative programs study their referral patterns to postacute services, standardized selections, and care expectations.

Clinical integration is the next consideration. Many programs have created clinically integrated networks of providers who, by agreement, coordinate and collaborate in the provision of care based on consistent guidelines, pathways, protocols, and desired outcomes. In addition to more purposeful integration between cardiology subspecialists, clinical integration efforts have been effectively focused between cardiology and primary care physicians, cardiologists and hospitalists, and cardiologists and emergency department physicians.

Finally, value-based outcomes marry clinical and financial metrics and outcomes and begin the process of measuring and managing value-based performance. Although most programs often begin with performance optimization to meet government incentives, such as reducing readmissions, they are quickly expanding to include cath lab performance, operating room performance, and other measures.

WHY IS THIS TRANSITION SO DIFFICULT?

The health care delivery system is a human system. It is based on unpredictable patient encounters, as well as physicians and other providers who are independent thinkers accustomed to managing their individual patients, individually. Reconciling the clinical approach among providers who were trained in different institutions with differing care approaches and standards, as well as at different times in the evolution of technology and medicine, and with different success and failure experiences is tedious, laborious, and humbling work. The paradigm shift to a systems- or population-based approach is counter to the physician and provider training and traditional successful practice behavior—it is just plain hard to make this adjustment. Several important resources are necessary to enable the population health pursuit. Information technology solutions are of particular importance in providing guidance on the adherence to agreed-upon care standards and protocols. Information technology is also critical in facilitating the efficient and accurate recording of clinical data. Unfortunately, most information technology solutions have fallen short of enabling the strategies that have been described. Furthermore, transparency in performance is not commonplace among physicians, and adding financial data to the clinical data evaluation is not intuitive.

There are also a number of external factors creating barriers. Today's regulatory and legal environment does not support many of the collaborative approaches. Malpractice insurance and tort reform are major impediments to the pursuit of collective clinical strategies, and the lack of leadership and operations management skillsets often falls short of the needs. Perhaps the most challenging barrier to solving the new clinical delivery model riddle is having the vision and engagement to do so—the knowingness that change is necessary and will result in a better system.

WHERE TO START?

With all transformative efforts, change occurs incrementally. Transformation is not prescriptive, but it can start and build from many vantage points. Some logical starting points for programs ready to move down the road to transformation starts with re-envisioning quality performance. Quality will be measured both at the individual operator level and in the aggregate. The criteria will include registries, but will also stretch beyond into patient selection and transparent outcome analysis. Quality performance will be transparent to patients and will become an “everybody activity,” not one that is relegated to the quality department. The first step of many programs is to reimagine their approach to engaging their physicians in a contemporary view of what quality management looks like for their institution.

All programs have the ability to measure something; figuring out exactly what to measure is the challenge. First, one must become familiar with and learn to manage unit-based quality and financial data. A program's ability to evaluate cost and quality at the per-unit level varies considerably. Some programs have invested in data warehouses and developed data analytic capabilities that require only attention to what can be produced. Others still lack in cost accounting systems and can only estimate performance.

Next, solve current financial problems, such as the two-midnight rule, by developing a protocol-based approach to same-day cath lab and electrophysiology lab discharge. In the past several years, coding changes to cath and electrophysiology lab procedures have resulted in patients receiving services on an outpatient basis. Many programs continue to treat those patients as inpatients, which is considerably more expensive. Collaboration between physicians and cath lab and other hospital staff can result in protocols and care process changes so that patients who are in an outpatient status are discharged from the facility in the outpatient status time frame.

It is also important to understand the best pathway for postacute care, studying patient outcomes, and adhering to a consistent clinical approach. Collaborate with hospitalists and physicians in the emergency department, develop and deploy a patient pathway for areas of high patient transitions (such as acute myocardial infarction and decompensated heart failure), and transition patients from hospital facilities to postacute care plans that are collectively defined. Finally, measure the results of each of these initiatives and understand the value of their impact.

SUMMARY

Whether or not the payment models change to an accountable care organization–like model, pursuing population-based strategies holds great promise for improving patient care. Connecting care through purposeful transitions, coordinating organizationally and clinically with other providers participating in the care of the patient, and creating clinical protocols based on evidence has been shown to do just that. The population health strategies—although not currently realized on a large scale—also promise to improve the cost of health care. So, the real question is—what are we waiting for? ■

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