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Population Health NEWS

NCQA's Approach to Population Health Management

by Natalie Mueller, MPH; Raena Akin-Deko, MHSA

If a patient's journey through the health system is fragmented and uncoordinated, the result can be increased costs and poorer outcomes. Applying a population health management strategy can help health plans identify individuals' needs and deliver appropriate, person-centered care through targeted interventions.

Although aligning operations to manage populations can reduce duplicate efforts and inefficiency, many health plans do not have a clear, defined framework for population health management.

The Industry's Journey to Population Health Management

Health care expenditures account for 17% of the gross domestic product ($17 trillion) in the United States, estimated to be 20% by 2020.[1] Although U.S. health spending is the highest in the world, life expectancy is significantly shorter than that of other industrialized nations. Guided by the Institute for Healthcare Improvement's (IHI) Triple Aim framework, the federal government, states, health plans and other stakeholders are tackling this challenge through various initiatives. The Triple Aim has three main objectives: better health, lower costs and better patient experience.[2]

The Triple Aim created a shift in the delivery of and payment for health care in the United States. In past years, most health care spending occurred through traditional fee-for-service (FFS) payment models, but with the Triple Aim as a guide, the focus shifted to payment for quality through value-based payment (VBP) arrangements, using population health management to tackle issues in member experience and quality of care.

Population health management did not develop in a vacuum. Federal policy and others have driven population health management and value-based care to the forefront of health care.

(continued on page 2)

In This Issue

Coming in March's Medical Home News Supplement

- Whole Person Care Demonstration Project Aims to Create Medical Home for Low Income Californians
- Study Links Primary Care Physicians to Increased Life Expectancy

Improving Population Health Through Technology: What Providers Need to Know

by Zachary Blunt, manager of product management, population health at Greenway Health

Technology is the answer, but what was the question? English architect Cedric Price famously asked. Then, he was referring to the application of technology in architecture, but this quote is equally as relevant to today's healthcare market as providers increasingly adopt a vast array of new technologies to enhance patient care.

So, if technology is the answer, what is the question healthcare providers seek to answer? For many, that is "How can I provide value-based, proactive healthcare to my patients and improve overall population health?"

Technology is the key to this complex equation. Today's cutting-edge solutions enable healthcare professionals to leverage data in ways never before possible. And, by applying advanced analytics, this data can deliver new insights about what patients need and how providers can deliver care when and where it's most appropriate. These insights can increase interactions with patients when costs are lower, and ultimately improve overall population health.

(continued on page 5)

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Editor's Corner

Greetings readers of *Population Health News*. We are pleased to be bringing you another excellent edition of the newsletter. In this issue we have a special focus on how technology can help population health and how population health initiatives can help alleviate the Opioid Crisis that is currently ravaging much of the United States. We also have an excellent contribution from NCQA on their approach to population health management. Thank you again for subscribing and please don't hesitate to reach out to me personally if you have any questions, comments or concerns. We also welcome user suggested content and ideas for articles.

Kind Regards,

Peter Grant
Editor, *Population Health News*
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NCQA's Approach to Population Health *...continued from page 1*

These public and private drivers include:

- **The Affordable Care Act:** With the passage of the Patient Protection and Affordable Care Act (ACA) in 2009, new types of value-based care models arose to provide the structures and systems that promote population health.[3]
- **The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA):** MACRA seeks to move health care from the FFS payment structure to a model where providers take financial responsibility for care while also improving the quality of care. This is accomplished through the Quality Payment Program, which assesses clinician performance on measures of quality and cost.[4]
- **Employers:** Increased productivity and lower health care costs are top priorities for large employers. Many employers believe that integrating primary care and population health management solutions into their health care offerings can produce beneficial results for their company and for employees,[5] and seek partners that use population health management strategies.

NCQA and Population Health Management

NCQA Accreditation helps organizations win business, meet regulatory requirements and distinguish themselves from the competition. Health Plan Accreditation is NCQA's flagship program. Launched in 1991 and modified in 1999 to include results of clinical performance (HEDIS®[6] [Healthcare Effectiveness Data and Information Set] measures) and consumer experience (CAHPS®[7] [Consumer Assessment of Healthcare Providers and System] measures), it is the most comprehensive evaluation in the industry and the only assessment that uses these measures.

More than three-quarters of all covered lives (173 million people) are enrolled in NCQA-Accredited plans. Accreditation standards and guidelines reflect almost three decades of experience and cover a variety of topics including quality management and improvement, network and utilization management, credentialing and member rights and responsibilities.

In 2018, NCQA created a new category of Health Plan Accreditation standards: Population Health Management. This category reflects a population-wide focus on care management. Through a consensus-based, iterative review process conducted with leaders in population health management and value-based care, standards were evaluated for inclusion in Health Plan Accreditation 2018.

NCQA defines population health management as a model that addresses the individual's health needs at all points along the continuum of care—including in the community setting—through participation, engagement and targeted interventions. Effective population health management should maintain or improve physical and psychosocial well-being and address health disparities through cost-effective and tailored health solutions.[8]

(continued on page 3)

NCQA's Approach to Population Health Management … *continued from page 2*

The Population Health Management standards in NCQA Health Plan Accreditation were designed to move health plans toward a more patient-centered, comprehensive approach to population management, which encompasses patient needs at each level of risk.

NCQA recognized that other entities—including vendors, PCMHs and ACOs—were performing population health management on behalf of payers and purchasers. To accommodate this variety of organizations, NCQA's evaluation strategy had to apply a flexible, yet cohesive, approach.

NCQA's Population Health Management Conceptual Model

NCQA developed the Population Health Management Model (right) to highlight the elements of a comprehensive strategy. A key element of the model is that it can be applied across different types of entities and to any entity carrying out the functions of population health management. It helps demonstrate how activities across entities work together to create a comprehensive strategy that addresses the needs, preferences and values of a population[9] and allows organizations to be flexible in determining where to focus interventions.

In a shift from a single, disease-centered approach to care delivery, the model's primary focus is the person or population—a "whole person" approach. The center population is interchangeable: It can be the entire health plan membership, a physician's patient population, people in a specific disease state (e.g., diabetes) or a specific population (e.g., 65 and older, members receiving long-term services and supports).

Surrounding the population are components critical to implementing successful population health management, including population identification, data integration, stratification, measurement, care delivery systems, health plans and payers and community resources.

NCQA's Population Health Management Program Suite

Multiple NCQA programs support population health management: Case Management Accreditation, Wellness and Health Promotion Accreditation and Certification—and its two newest programs, released in December 2018, Population Health Program Accreditation and Population Health Management Prevalidation.

Population Health Program Accreditation

NCQA developed Population Health Program Accreditation for entities that deliver targeted interventions to specific populations. The Accreditation is based on the Population Health Management Conceptual Model, aligning standards in Health Plan Accreditation and Population Health Program Accreditation requirements. As a result, this program is especially meaningful for organizations that manage programs delegated from, or in support of, health plans.

Population health programs eligible for Accreditation can be condition- or population-based. Programs may focus on individuals with a single index disease or condition (e.g., diabetes, asthma, high-risk pregnancy), focus on multiple conditions or focus on a targeted population across conditions to manage specific risk factors (e.g., reduce inpatient admissions for ambulatory-sensitive conditions).

Benefits of Population Health Program Accreditation include:

- **Improve Operational Efficiencies:** Standards are based on best practices. Organizations can align operations to manage population health needs efficiently and reduce duplicated efforts and waste associated with misaligned goals.
- **Support Contracting Needs:** Organizations can use the standards to implement effective, targeted population programs that meet the needs of employers and payers.
- **Provide Added Value:** Organizations that meet the standards can offer automatic credit for eligible population health management requirements to organizations seeking Accreditation, reducing administrative efforts.

The program standards align important functional operations, including data integration, population assessment, population segmentation and targeted interventions.

(continued on page 4)

NCQA's Approach to Population Health Management ... *continued from page 3*

Entities eligible for this Accreditation include, but are not limited to, population health management organizations; disease management organizations; health plans, including HMOs, PPOs and POS plans; MBHOs; provider organizations, including medical groups, hospitals and integrated delivery systems; and case management organizations.

Population Health Management Prevalidation

Health IT tools that earn NCQA Population Health Management Prevalidation demonstrate that their functionality helps support or meet NCQA standards. Organizations submit documentation to NCQA about the solution's functionality. NCQA determines if the solution fully or partially meets criteria for certain functions and whether credits can be awarded. If a tool earns automatic credit status, organizations that use the tool can receive automatic credit for those functions during their Accreditation Survey and are not required to submit supporting documentation as part of the Accreditation process. Organizations that use the tool can assure customers that they can support their population health management goals.

Trends to Watch

While developing the new programs, NCQA noticed that certain trends are important areas for development for population health management entities and stakeholders. We think these areas bear watching as organizations embrace population health concepts and new technologies:

- **Social determinants of health and integrating community resources.** Social determinants of health are economic and social conditions—where people are born, live, learn, work, play, worship and age—that affect a wide range of health, functioning and quality-of-life outcomes and risks (e.g., safe housing, access to educational and economic opportunities, social support, exposure to violence), and play a fundamental role in the health of a population.[10] A meta-analysis found that social factors such as education, racial segregation, social supports and poverty accounted for over a third of deaths in the United States each year.[11]

  "A meta-analysis found that social factors such as education, racial segregation, social supports and poverty accounted for over a third of deaths in the United States each year."

  Assessing social determinants of health is necessary for understanding a population's characteristics and needs, and in many cases, provides insight into services that can improve health and quality of life. Often, community resources and supports can fill service gaps: Collaborating with a local community health worker program or other referral sources (such as a social worker) can connect hard-to-reach populations, including underserved, vulnerable and rural populations, to needed resources. In addition, NCQA-Recognized PCMHs reduce socioeconomic disparities by providing better access to care for vulnerable populations.[12]

- **Payer and care delivery system engagement through VBP arrangements.** Practitioners drive 75%–85% of quality and care decisions.[13] Engaging with these and other entities involved in care delivery can help implement strategies to improve quality of care and reduce costs. Engagement and support can come in a variety of ways, including through support of VBP arrangements.

  CMS has outlined common VBP arrangements (e.g., pay-for-performance, shared savings, shared risk, two-sided risk sharing, capitation) that share the goal of moving away from FFS and toward value-based care. The design and implementation of a VBP arrangement must consider three influences:[14]

  1. **External environment:** Regulations, payment policies, member preferences, quality improvement initiatives.
  2. **Provider characteristics:** Health-care system structure, organization culture, available resources and capabilities, population served.
  3. **Program features:** The defined member population, program goals, measures, financial incentives, risk structure.

  "Practitioners drive 75%–85% of quality and care decisions."

  Providers and practitioners might be concerned that they are ill-equipped to transform to value-based care and do not fully understand VBP arrangements,[15] but payers are uniquely positioned to ease these concerns by:[16]

  - Explaining integrated and value-based care.
  - Expanding the provider's reach through access to care management resources that go beyond information gained from office-based primary care.
  - Leveraging activities to improve quality measures.
  - Offering a spectrum of VBP options to allow a balance between value-based incentives and financial risk exposure.

NCQA Background and Resources

NCQA is a private, nonprofit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations. It also recognizes clinicians and practices in key areas of performance. NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely used performance measurement tool in health care. NCQA's website contains information to help consumers, employers and others make informed health care choices. Find NCQA online at ncqa.org, on Twitter @ncqa, on Facebook at facebook.com/NCQA.org and on LinkedIn at linkedin.com/company/ncqa.

(continued on page 5)

NCQA's Approach to Population Health Management … *continued from page 4*

NCQA created the *Population Health Management Resource Guide* with sole sponsorship funding from Janssen Scientific Affairs, LLC (Janssen). Although Janssen had no specific input into the guide's content, Janssen and NCQA share the belief that the future of health care delivery requires greater collaboration between the many diverse areas of health care and a move toward achieving population health. The Resource Guide can help plans develop their population health management strategy, and help identify best practices for achieving their goals. Download it at http://www.ncqa.org/PHMResourceGuide.

Margaret E. O'Kane, founder and President of NCQA, will discuss Developing Standards With Population Health Program Accreditation at the Population Health Colloquium in Philadelphia on March 18–20.

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Improving Population Health Through Technology: What Providers Need to Know … *continued from page 1*

Initiatives Drive Focus on Population Health

As the healthcare industry continues to move to a value-based care model, population health is more dynamic than ever before. Despite being in the early stages of experimenting with risk-based agreements, 83 percent of healthcare executives say population health is critically or very important, according to The State of Population Health: Third Annual Numerof Survey Report. And it's not surprising why, considering 97 percent of these executives expect population health initiatives to offer a significant opportunity to gain control of clinical costs, as well as improve quality of care and patient outcomes.

> ***"97 percent of these executives expect population health initiatives to offer a significant opportunity to gain control of clinical costs, as well as improve quality of care and patient outcomes."***

New programs focused on implementing value-based care initiatives and measurement of key metrics could be another reason population health is top of mind for healthcare executives. The Centers for Medicare & Medicaid Services (CMS) recently introduced several programs and now expects half of Medicare payments to be structured according to value-based models. Commercial payers are taking a similar route, announcing their own value-based care programs and set payment goals. The Medicare Access & CHIP Reauthorization Act (MACRA) also established the Merit-based Incentive Payment System (MIPS) that links fee-for-service payments to quality and value. MACRA is designed to promote delivery of better care, encourage smarter spending and result in a healthier population.

Population Health Starts at the Practice Level

An effective population health management strategy begins at the practice level, since it is fundamentally about managing the health of a defined group — whether it's based on geography, age, disease or behavioral factors — by providing the right intervention at the least costly point in the care continuum. To achieve this, practices must improve care coordination, enhance health and wellness, eliminate disparities, and increase transparency and accountability — all with the goal of delivering higher quality care to their patients at lower costs across the board.

(continued on page 6)

Improving Population Health Through Technology: What Providers Need to Know … *continued from page 5*

To understand how to execute on these activities and reach the ultimate goals, healthcare providers need to:

- Identify which patients are most in need of care
- Manage care by identifying gaps
- Engage patients by creating and following up on care plans

While these three points may seem obvious, effectively acting on them requires the help of technology.

Solutions to Support Population Health Initiatives

Successfully enacting population health initiatives requires the integration of a number of diverse technologies and solutions, including telemedicine, patient dashboards and scorecards, patient engagement tools, data warehouse and data aggregation, and much more.

These solutions must be able to integrate with existing electronic health records, practice management systems and entities across the healthcare community. By tying together these common platforms with new technologies, the healthcare community can aggregate clinical and financial data to gain real-time visibility into key performance metrics, such as Healthcare Effectiveness Data and Information Set (HEDIS) and those related to Accountable Care Organizations (ACOs). Additionally, with integrated care management platforms, practices and providers can gain control of their workflow, enabling them to better engage with patients and ensure intervention at the right time to optimize health outcomes.

Data Overload? Not a Problem with Advanced Analytics

These new solutions enable access to data like never before. For providers to ensure strong insights from data, consider the "four V's":

- **Volume –** The amount of data stored, including electronic patient records, medical imagery, FDA clinical trial submissions and human genetics studies.
- **Velocity –** The speed at which data accumulates.
- **Variety –** Healthcare data comes in multiple formats, from numerous sources. Only about 15 percent of that data is structured, like test results and patient information. The rest is unstructured and is gathered through doctors' notes, imagery, wearable devices, mobile apps and other sources.
- **Veracity –** The accuracy of healthcare data, covering everything from patients' names to prescriptions to billing codes and more.

> ***"By 2020, IDC estimates that more than 2,314 exabytes of healthcare data will be generated annually — enough to fill the typical PC about 100 billion times."***

To optimize insights from healthcare data, the four V's must work together. Volume and velocity are increasing at astronomical rates. By 2020, IDC estimates that more than 2,314 exabytes of healthcare data will be generated annually — enough to fill the typical PC about 100 billion times. While volume and velocity explode, veracity must keep pace to ensure information is accurate and useful. At the same time, to get clear pictures of entire populations, variety is just as important.

Bottom line: The sheer quantity of healthcare data can be overwhelming if there's no way to analyze it. In the list of solutions cited in the HIMSS survey, analytics is frequently mentioned, and these types of tools are critical for closing performance gaps. With the right analytics in place, providers can gain critical insights. For example, in much the same way retailers use data to predict customers' buying habits, healthcare providers can leverage data to learn more about the populations they treat. By analyzing data related to patients' age, social and economic demographics, relative fitness and other factors, providers can improve population health management efforts and target care delivery for better patient outcomes.

Additionally, applying analytics to healthcare data can help reduce patient risk by identifying behaviors, environments and other factors. With this information, providers can identify high-risk patients and take the proactive steps necessary to prevent progression of disease or encourage a healthier lifestyle. Providers also can identify open care gaps for preventive screenings or annual wellness visits, or measure clinicians' performance over time to ensure they are applying best practices.

By leveraging technology — from new platforms to advanced analytics tools — providers can gain a holistic view of patient needs, the cost of care, and when and where improvements are necessary. The application of these technologies will be critical for the healthcare community to make strides in further improving population health through value-based care.

About the Author

***Zachary Blunt** is the manager of product management, population health at **Greenway Health**, a leading health information technology and services provider. He has worked in the healthcare industry for more than eight years and has been a member of the Greenway team for five years. At Greenway, Zach focuses on the company's population health and patient engagement tools — he has a passion for improving patient behavior toward their overall health goals. Zach is an MBA candidate in the University of Florida program and received his Health Information Technology and Health Information Exchange Specialist Certificates at the University of Texas at Austin. He currently resides in Tampa, Florida.*

Population Health Technology Needs to Evolve With Providers

by Mike Hoxter

Population health management (PHM) has been an often discussed phrase over the past decade. Google Trends shows its search volume increased steadily between February 2009 and February 2019. In the world of health information technology (HIT), however, 2009 is ancient history. Consider this: just a decade ago, nearly 88 percent of hospitals were still using *paper charts*.

As electronic health records (EHRs) proliferated in the early part of this decade, so did other platforms to help health systems, practices and accountable care organizations (ACOs) leverage the accumulated electronic data to better manage populations of patients for value-based care (VBC) payment models.

The good news is that the provider organizations and HIT developers have made huge strides in that time. PHM and VBC, together with the rapid implementation of EHR systems, have created new data-driven, prevention-focused care management teams and provider workflows in healthcare organizations across the country.

As such, PHM platforms and analytics solutions designed to help manage PHM and VBC need to continue to evolve with the organization. These systems need to lead providers and payers toward new competencies through innovative features and functionality. Delivering more relevant and reliable data to providers at the point of care to close care gaps is one such priority. Likewise, point-of-care providers, care management staff and PHM leaders need instant, but highly customizable snapshots of their performance across any VBC or related program. Finding and referring to high-quality providers also needs to be more simplified, automated and transparent.

These are just some of the considerations our six-year-old company, Lightbeam Health Solutions, had in mind when we were developing the 3.0 version of our PHM platform. Released in February, the updated and redesigned system maintains the strengths of our unified end-to-end solution while adding essential features for PHM and VBC in 2019 and beyond, particularly focused on empowering providers with relevant data at the point of care.

Insight Within the Workflow

A troubling, but familiar, study from Stanford Medicine released last year shows that 62 percent of physician time devoted to each patient is spent in the EHR, and 70 percent of physicians believe the technology is contributing to burnout.

> ***"62 percent of physician time devoted to each patient is spent in the EHR, and 70 percent of physicians believe the technology is contributing to burnout."***

Although Lightbeam does not build EHRs, we were motivated by these survey results and many others with similar disheartening results as we began to develop the 3.0 version of our platform. We wanted to alleviate providers from that EHR burden so they could automatically see the care-gap and intervention opportunities, and act on them more easily without having to dig through their digital charts or one of our applications.

We conducted focus groups of physicians and other users, particularly our ACO and Medicare Advantage clients. We observed them in clinical settings using our solution and tested beta versions of 3.0 with these same users. The results of this R&D can be found in many places throughout the new version, but especially in our Provider Insights chart, a new feature that delivers instant visibility into how quality measures impact provider reimbursement and performance bonuses.

The chart quantifies the economic value of closing gaps in care and quality measures for each provider so they can visualize how their performance impacts payment incentives. New provider engagement views identify each quality measure providers are accountable for and how they are tracking toward their target compliance rate, which means they no longer have to wait for reports and hope their performance exceeds requirements.

The impetus for this feature came from talking with and observing our user groups. It became clear that providers wanted an easy-to-interpret view of how they were performing on key quality measures with less searching. In fact, many providers wanted this view to be the first screen they see when opening our platform. By prioritizing this feature in the system, we reduced the number of clicks required to view the insight from seven to one.

Faster, More Relevant KPIs

Similar to provider performance metrics, the idea of developing and tracking other key performance indicators (KPIs) was a relatively new concept in healthcare in the early 2000s, especially concerning clinical KPIs. In the early days, healthcare organizations used spreadsheet software or other non-clinical office applications to monitor KPIs. Since then, PHM and analytics platforms have delivered much more efficient, flexible and highly visual tools to help providers gauge performance.

Yet we noticed while developing 3.0 that the KPIs that providers received were not always relevant or easy to find. In some cases, they were either too broad, which meant the providers only had a vague idea of their performance, or they were so specific to a certain payer, metric or provider, that it was meaningless to other users. If the providers wanted to change the KPI, they were unable to uncover specific insights, or it required too many steps.

That is why our new KPI dashboard was designed for optimum provider and end-user adoption. It tracks cost, quality, and utilization in areas that drive VBC reimbursement.

(continued on page 8)

Population Health Technology Needs to Evolve With Providers … *continued from page 7*

This dashboard contains distinct panels that can be easily filtered by contract, such as cost and utilization, wellness visits, MA trends, transition of care, risk scores, and static cohorts so providers can easily pinpoint areas that need improvement.

New Insight into Risk

Another new concept for many provider organizations that arrived with PHM and VBC was the concept of risk stratification and management. These concepts are the foundation of insurance, but providers needed a crash course if they were going to accept shared and full-risk-bearing contracts. Payers helped with the learning curve by providing claims data, but this information was often dated and not very useful for identifying the highest-risk, highest-need patients.

Version 3.0 overcomes these limitations with enhanced analytics for MA plans and participating provider organizations. Using our enterprise data warehouse, this predictive analytic tool overcomes claims lag time by combining real-time, comprehensive clinical information, lab data, and other information to identify hierarchical condition category (HCC) coding gaps. In addition, the system searches for suspect codes which suggest there are missed diagnoses for existing or developing conditions. These instances would mean updating the risk adjustment factor (RAF) score CMS uses to determine payments. By finding those coding gaps and helping MA plans form the most accurate RAF scores, providers ensure optimal reimbursement from these plans and improved outcomes for patients.

Automating High-Quality Referrals

While risk stratification and KPIs in healthcare are relatively new, physician referrals are not. Yet even in 2019, many physician referrals are based on relationship, not necessarily on quality or outcomes. For example, a physician will recommend a patient should schedule an appointment with a former colleague, a fellow medical school alumnus, or simply an acquaintance from a conference or community organization. While that referral partner may be appropriate for the patient, referring in 2019 should not be the same as it was 1919.

One of the primary reasons is patients now have a greater personal financial stake in their healthcare services and often want to stay within their health plan's network to keep their spending lower. Similarly, health plans are narrowing their networks to smaller groups of high-quality providers to reduce premiums and out-of-pocket spending for their members and improve outcomes. A narrow network can also be affiliated with an ACO and it is the best interest of the referring physician to keep the patient within that network.

Physicians should, of course, refer to whomever they feel is the most appropriate for their patients, but they should have the cost, quality and geographic information easily available to make the best decision and not simply rely on relationship or memory.

Within 3.0, a new referral management module addresses this critical role that referrals and narrow networks play in value-based care arrangements. Now, instead of relying on a physician's personal preference alone, or performing a random search and hoping for the best, the module identifies the impact referrals have on cost, quality, and revenue. The workflow and decision support tool helps referral coordinators build a high-quality network, control leakage, and track referral patterns while ensuring the loop is closed between patients and providers. This means when the patient completes the appointment with the recommended provider, a confirmation and crucial data are automatically captured by the new module and integrated into the PHM system and patient chart.

Streamlined, Faster Interface

All of these new features, as well as the other applications within the platform, are unified under a redesigned, streamlined user interface, which had not received a significant update since we launched six years ago. Our motto with the redesign: "Reduce the clicks." We scoured every application and feature to figure out ways we could reduce the steps, automate routine processes, and deliver providers data they need without searching.

Like the new modules, the user interface redesign was the result of client feedback and user-group study. Combined, the 3.0 interface delivers a uniquely intuitive look with access to the same valuable insights as before. New features also include a collapsible navigation bar similar to Windows 10 and simplified views with improved responsiveness. As a result, providers are able to increase throughput and care managers are able to reach out to more patients in less time.

Improving Value Through Positive Productivity

As the industry has shifted from fee-for-service to PHM and VBC, much of the discussion has focused on care quality and reducing the cost of care. As technology capabilities and provider competencies have increased, the industry is realizing that productivity is still important in the VBC world. The key differentiator, however, is that productivity cannot be at the expense of provider burnout or patient experience.

Throughout our redesign of Lightbeam 3.0, our focus was how to help providers accomplish more, but in less time and with less burden. Through the new modules, automated and actionable analytics and streamlined, intuitive layout, we believe we reached that objective.

Even with this accomplishment, new updates are on the way, including advanced analytics to make reporting more relevant and ways to factor in data from claims that have not been adjudicated by the payer. As always, our platform, like the providers and payers we serve, never stops improving.

About the author:

Mike Hoxter is chief technology officer of Lightbeam Health Solutions.

Thought Leaders' Corner

Each month, *Population Health News* asks a panel of industry experts to discuss a topic suggested by a subscriber. This month, there are two questions.

Q. How can population health initiatives combat the opioid crisis?

Collaboration is key to leveraging population health to combat the opioid crisis. In our current system, care is very siloed, and as an industry, we need to break down these barriers and work together by promoting collaboration. This includes individuals and organizations on the front lines and dealing with the crisis each day. By promoting collaboration, we can expedite and improve access to the right kinds of treatment. For example, by collecting surveillance data for overdoses in a rigorous way, we can then implement prevention and treatment programs in a targeted way to combat addiction based on those data.

As a critical care physician, I have treated a number of overdose patients who are brought into the emergency department. Once they wake up, they are often discharged and sent home. As clinicians, we think our job is done, but in reality, that is far from the truth. Sometimes we become hyper-focused on addressing the acute medical condition, while other times, we just simply do not know how to address the underlying behavioral health issues. But to really make a difference in combating the opioid epidemic, medical clinicians need better linkages to those providing evidence-based assessment and treatment to address the underlying behavioral health condition. It takes a village to support people through addiction, and that includes after they leave treatment. People need support to rebuild their lives and stay healthy, including reconnecting with loved ones and gainful employment. As medical and behavioral practitioners, we often neglect the importance of this support, but it is necessary to ensure positive outcomes.

If we look at the larger picture of addiction, based on cost savings alone, it is clear we also have a monetary reason to address this concern and get it right. If a person suffering from addiction undergoes treatment, then gets and stays healthy, that amounts to around a $15,000 cost savings. For example, if 10,000 Medicaid patients were suffering from substance use disorder (SUD), a mere 0.5% reduction in those cases is staggering; it amounts to a total $750,000 in cost savings. Those numbers are impressive on their own. Imagine what this might look like at scale – on the city level, by county, by state, and nationally.

Technology can help us get there. Local and state governments are leveraging software to identify gaps in care delivery and direct funding toward programs that work. This is, of course, one of the primary challenges – ensuring that money is funneled into what has proven to be effective. Medication-assisted treatment is one of these programs that has been proven to work. By sharing best practices with positive outcomes, other governments can also effectively fund and support the right strategies.

Lack of experience and knowledge in the healthcare industry can make it challenging to navigate SUD in particular. Access to the right behavioral health treatment for people suffering from SUD can make a difference. This includes increasing the utilization of prescription drug monitoring programs (PDMPs) and leveraging validated screening tools to help identify those most at risk. Today, with the help of technology and decision support tools, medical professionals, firefighters, crisis call line operators and others are able to get people in to the right level of treatment when they need it. While leveraging this type of technology is only a small part in the overall objective, it is an important one that helps communities begin to fight the opioid crisis.

Nishi Rawat, MD
Co-founder & CEO, OpenBeds

Thought Leaders' Corner

If you haven't turned on the news, read an article or even more disheartening, had a loved one overdose on drugs, you may not be aware of the opioid crisis in the United States. In 2017, approximately 47,600 persons overdosed on opiate class drugs, according to the CDC. How did we get here? And more importantly, how can we help?

I think one of the most important things we can do to help ensure that everyone is educated on the opioid crisis, is to simply get the word out that it is ok to ask for help. Opioid addiction is not a moral failure. It is a disease. If your son or daughter is sick, you take them to the doctor. If that same son or daughter breaks his or her leg on the playground, you take them to the emergency room. If your spouse is complaining of chest pain, you rush him or her to a specialist or emergency room. Why is it, if our loved one is using heroin or narcotic pain pills that we suffer in silence? We do not love them any less; we just may not understand the urgency or depth of this deadly disease. We want them to get help and to come out on the other side healthy and happy again. So, with that in mind, what can we do?

Understand that no one wakes up and decides to be an opiate addict. It starts in a variety of ways, often times very innocently. A student athlete injures his knee and has surgery. The pain is horrific, no doubt, but he takes more of the pain pills than he should. It is not easy to stop. A mother has a C-section with complications. She loses her baby and is dealing with grief and the pain from the complicated caesarean. She takes a few more pain pills each day to get through the pain.

In both scenarios, a loved one has to step in and ask for help. We also have to be willing to receive the help that will save them. There are a variety of treatments options available for opiate addiction. Medications such as Methadone, Buprenorphine and Vivitrol are some of the most researched and evidence-based ways to treat this disease. Medications can help manage the symptoms of withdrawal that often leads to relapse and helps the patient engage in other treatments.

I've worked in the field of opiate addiction for 25 years and I still have loved ones and friends who suffer in silence. In a world full of pressure to be the perfect parent, partly due to the pressures from social media and corporate America, it is hard for us to admit our little worlds or our precious children, spouses, parents, cousins, close friends, are not perfect. What I can say, is educate your children early. Let them know it is not ok to take a pill from a friend at school. Make sure you do not keep leftover narcotics from a surgery or injury in your possession. There are places to drop off pills at most law enforcement agencies across America. Do not take the chance that those pills end up in the wrong hands.

The difference between today and 25 years ago is that drugs are being manufactured with deadly substances. All it takes is one "bad batch" and your loved one could be gone. Know the facts. Know the signs. Know how to get help. Narcan, a reverse agent, can save a life from overdose and is available by prescription and often times over the counter. If you think your loved one is using, ask your physician for a prescription. Learn how to administer it and be prepared.

Holly Broce, MHA, LCADC
Vice President of Opioid Treatment Program Division, Pinnacle Treatment Centers
President, Kentucky Chapter, American Association for the Treatment of Opioid Addiction (AATOD)

Industry News

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Aligning Care. Advancing Health.

Partners Behavioral Health Selects Casenet's Population Health Management Platform

Casenet, LLC announced that Partners Behavioral Health Management in North Carolina selected TruCare, Casenet's population health management platform, to support care coordination and population health initiatives for its members. Partners is a managed care organization specializing in managing mental health, substance use disorder, and intellectual and developmental disability services for individuals in North Carolina covered by Medicaid or state health insurance.

To prepare for the rapidly changing landscape in North Carolina healthcare, Partners initiated the search for a technology solution that could identify and stratify populations at risk, identify gaps in care, enable coordination among care team members, facilitate engagement with providers and members, address social determinants of health, and establish real-time clinical interoperability with providers via Electronic Health Record and Healthcare Information Exchange systems. The technology also had to be agile to evolve with North Carolina's Medicaid transformation efforts. Partners selected TruCare after evaluating a handful of population health solutions.

"Interoperability among disparate systems is a critical factor for us," said Rhett Melton, CEO of Partners Behavioral Health Management.

(continued on page 11)

Industry News

Partners Behavioral Health Selects Casenet's Population Health Management Platform *...continued*

"We need to make connections with our members, providers, and the state to get a 360-degree, longitudinal view of each member to improve care. TruCare has the technology in place that allows health information systems to work across organizational boundaries."

Partners will implement TruCare's care management, utilization management, and disease management functionality to enhance care coordination for members with complex conditions. In addition, Partners will implement TruCare's Home and Community Services module to identify members in need of non-medical support and match them to community providers.

"We are thrilled to work with Partners Behavioral Health Management," stated Peter Masanotti, Casenet's Chief Executive Officer. "Our products are specifically designed to coordinate care across the continuum of care so that providers can treat the whole person. Behavioral health is a critical component of overall health and wellbeing."

Altruista Health Selected by Health Alliance for Care Management & Population Health

The Altruista Health, an innovative provider of care management technology solutions, announced that Health Alliance has selected Altruista for a full suite of care management and population health modules following a comprehensive scan of the market. Health Alliance will implement GuidingCare® modules in Care Management, Utilization Management, Reporting, Appeals & Grievances and Population Heath. Health Alliance will empower plan clinicians with the Mobile Clinician app and plan members will use a GuidingCare portal.

Health Alliance is a provider-aligned health plan in Champaign, Illinois, and is part of The Carle Foundation, a vertically integrated health system that includes a hospital, provider network and health plan. Their more than 230,000 members are in the Midwest and Washington, and belong to both commercial and Medicare plans. Health Alliance joins the ranks of member plans from the Alliance of Community Health Plans (ACHP) that rely on Altruista and GuidingCare.

"Health Alliance partnering with Altruista Health to support our members makes perfect sense," said April Vogelsang, System Vice President of Population Health for Carle and Health Alliance. "Both of our organizations are committed to improving outcomes based on best practice standards. This technology will help us identify, collaborate and build relationships with our members in new and innovative ways."

The GuidingCare technology platform seamlessly brings together all the information needed for comprehensive care plans, integrating preventive and acute care, chronic disease management, behavioral health, long-term care and community services.

"We are delighted to welcome another ACHP plan to the fold because we know what a good fit our solutions are for community-based plans that are innovating models of care," said Altruista Chief Executive Officer Ashish Kachru. "The Health Alliance integrated model will rest on a single powerful platform offering a full picture of member health and complete coordination of care."

New Law Will Make All Virginia Schools 100% Free From E-Cigarettes and Tobacco

A newly signed state law will make all Virginia schools 100% e-cigarette-free and tobacco-free, 24 hours a day, 7 days a week. Youth advocates from Y Street, the Virginia Foundation for Healthy Youth's teen volunteer initiative, successfully advocated for the Comprehensive Tobacco-Free Schools Law, which was supported by the Virginia Department of Health and the Virginia Department of Education. The law will require all Virginia school boards to implement "comprehensive" policies prohibiting the use and distribution of all tobacco and nicotine vapor products by students, staff, and visitors at all times on school property and at off-site school sponsored events.

Since 2014, Y Street youth from across the Commonwealth have partnered with 23 school divisions to help their boards adopt 100% comprehensive policies as part of the 24/7 campaign. Their efforts led to more than one-third of Virginia'sK-12 student population being protected by such policies, and this new law extends that protection to all of Virginia's youth. Under the new law, school divisions will be required to identify disciplinary actions for staff, students, and visitors that fail to comply, as well as to offer referrals to resources to help individuals overcome tobacco addiction.

"As a student who already attends school in a comprehensive division, it means so much to me that the entire state is now become comprehensive, because I hope that all children across Virginia get to experience the same healthy academic environment that I am in every day," said Jessie Wang, a 10th grader and Y Street member at King George High School.

The new law helps schools address recent concerns over electronic cigarettes and vaping. From 2017 to 2018, vaping among teens in the U.S. spiked dramatically, with 3.6 million middle and high school students reporting that they currently use e-cigarettes. With the U.S. Surgeon General declaring e-cigarette use an epidemic, schools and school divisions have been clamoring for resources to protect their students. The new law ensures that all school division policies across Virginia cover current products on the market that may be attractive to youth, such as JUUL devices, as well as potential future products that have not yet hit the market.

To help with the implementation, communication and enforcement of the new policies, the 24/7 campaign will be offering free resources to school divisions across the state. They will provide free signs to help schools comply with the new law and communicate the 100% e-cigarette-free and tobacco-free policy.

Catching Up With ....

Monique Stanton

President & CEO
CARE of Southeastern Michigan

About CARE of Southeastern Michigan

CARE of Southeastern Michigan's mission is to strengthen the resiliency in people and their communities through prevention, education, and services that improve the quality of life. For more information, visit www.careofsem.com

***Population Health News**: What are some innovative new practices that Michigan emergency rooms are experimenting with to address the Opioid Crisis?*

Ms. Stanton: As deadly fentanyl continues to grip our nation, some hospital emergency rooms in Michigan have added another effective layer to their crisis response teams.

Until the last two years, southeast Michigan emergency department medical experts had few resources to help prevent individuals battling substance abuse – primarily fentanyl – from repeatedly returning to their emergency rooms due to overdose.

A hospital's emergency department's focus is just that, emergency response. It addresses immediate medical needs such as overdose. However, after that, until recently they have struggled to connect patients to substance use disorder treatments and support services.

This is until the integration of CARE of Southeastern Michigan's successful Peer Recovery Coaches, part of its Recovery United peer services. In four Detroit area hospitals operated by three different health systems, CARE's 16 peer recovery coaches spend 12 hours a day, seven days a week in emergency rooms. Trained in motivational interviewing, peer recovery coaches capitalize on their lived experience, engaging referred individuals who may not have been actively seeking an intervention or treatment for their substance use.

***Population Health News**: Can you describe in greater detail what these peer recovery coaches do?*

Ms. Stanton: Upon admittance to the emergency room peer recovery coaches engage individuals in a standardized screening and if they need addiction recovery services, CARE coaches work to get them into treatment or connected with other community support services.

Peer recovery coaches save lives. Entering an emergency room is traumatic, and an individual may not trust to confide in busy physicians or nurses. However, those struggling with substance use often trust peer recovery coaches who understand what they are enduring. Recovery United is critical in helping individuals navigate their recovery and our complex healthcare system, while managing family stress, joblessness, legal issues, health problems, and other issues typically accompanying substance abuse.

The success rate of CARE's program is fantastic. Since the program inception in May 2017, 1,883 individuals have been screened by CARE's program. Eighty percent requested a referral for additional services and more than 33 percent engage in some level of care post-discharge.

***Population Health News**: What is the primary goal of the program?*

Ms. Stanton: The program focuses on screening large of numbers of people to identify those who are misusing or abusing substances. The goal is to prevent people from falling through the cracks by helping them get connected to services as soon as possible. Coordinated care allows an individual's substance use to be addressed, even when they are not actively seeking help.

This project was created using state and federal funding aimed at combating the opioid epidemic. CARE reached out to national and statewide experts to develop a model that would be successful in southeast Michigan. Nonprofits nationwide can take initiative to do the same.

Our coaches treat individuals with the respect and dignity they deserve. Coaches follow individuals for 60 days upon hospital release to ensure they are on a successful recovery path. CARE is proud to be part of the solution to the deadly problem that loses 72,000 individuals every year.