Leveraging Data to Achieve Economically Viable Population Health Management

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Most healthcare organizations operate in pluralistic payment environments today, with significant portions of their revenue stemming from various arrangements along the payment spectrum—from fee-for-service (FFS) to shared savings, dual risk, capitation, and everything in between. The trend overall, however, is toward more risk-based payment models that are changing the relationships between payers and providers. CEOs and boards of hospitals and health systems, medical groups, and provider organizations of all types are grappling with the challenges stemming from the push toward value at the state and national level. As payers progressively delegate financial risk and accountability to providers, value-based payment models are incentivizing hospitals and health systems to develop population health management capabilities as a means for controlling costs and improving patient outcomes. Many of these organizations are just beginning to explore the world of downside risk and the management of attributed populations, whereas others are expanding their investments into existing population health management programs.

Organizations just getting engaged with or considering risk contracting arrangements and more advanced organizations alike are quickly realizing that the effective use of data plays an integral role in successful population health management. Many hospitals and health systems have access to troves of clinical and financial data, particularly through medical and pharmacy claims. Having a robust analytics strategy to understand in great depth the flow of dollars into and out of the hospital or health system is critical to reliably assess opportunities to enhance performance under current risk contract configurations. Through analytics, these organizations can better track the health of their members and impact the overall cost of care. In doing so, they can assess the historical and projected costs of the population, the financial impact of initiatives, and the viability of ongoing and prospective risk contracts.

How to Use Data to Enhance Population Health Efforts

When assessing performance in a value-based payment arrangement, organizations should adapt various key performance and quality indicators (KPIs) into their reporting systems. Traditionally, hospitals have relied on volume-based metrics to gauge performance. Metrics such as admission counts, patient days, and total discharges are effective in a FFS model but fail to address what matters most in a risk-based environment: the overall health of the provider's population. Rather, global per member cost and utilization metrics are key to better controlling and managing overall cost and quality and are used to measure the performance of specific populations. For example, measuring inpatient admits per 1,000 allows organizations to depict overall health and total costs while simultaneously identifying population health issues that require attention.

Organizations can further enhance their population health programs through meaningful segmentation of their members into populations and sub-populations—by disease state, geography, demographic, payer, network, etc. This allows for increased accountability, identification of inefficiencies, and realignment of resources across the organization. By aggregating clinical data into distinguishable segments, operational leaders can begin to identify opportunities to enhance services provided.

An example of this segmentation is the identification of diagnoses that are contributing to the highest costs within their population. For example, a health system may find that it spends a significant amount on knee replacements for its members. Typically knee replacements for patients without major chronic conditions can be done at an outpatient surgical center at a much lower cost than in an inpatient setting. Shifting these surgeries away from the hospital setting can not only reduce total annual per member costs, but lower the risk of hospital-acquired conditions and increase patient satisfaction. In addition to high-cost diagnoses, the organization may look to review its pharmacy and drug utilization. By analyzing pharmacy claims, it can assess appropriate use of generics, prescriber adherence to formulary drugs, and over and underutilization of specific drugs.

Additionally, through claims data, hospitals and health systems can identify how often their members are utilizing services outside of the organization's network of providers—often a large contributor adding to the total cost of care. Drilling down to the physician/practitioner level allows for referral patterns to be analyzed, and lays the groundwork for downstream investigations to identify specific causes. For example, an organization may discover

Key Board Takeaways

For healthcare organizations on or starting down the path to embracing value-based care delivery models, the board should:

- Ensure that the principles of population health management are reflected in the organization's mission and purpose.
- Assess the organization's population health management strategy and make sure that executive leaders are well positioned to manage risk.
- Incorporate population health management and data into governance and organizational decision making.
- Prioritize investments in data analytics, supporting IT infrastructure, and continued education.

To best utilize data, healthcare organizations should:

- ✔ Adapt various KPIs into their reporting systems.
- ✔ Aggregate clinical data into distinguishable segments.
- ✔ Identify how often members are utilizing services outside of the organization's network of providers and investigate why this is occurring.
- ✔ Employ data to pinpoint opportunities to increase revenue through premium enhancement and member management.
- ✔ Use data to set targeted benchmarks for organizational performance.

that a high percentage of outpatient cardiology diagnostic tests are referred to out-of-network specialists. In some cases, this may simply be due to the referrer not being aware of in-network resources or the financial impact of sending members out-of-network. In these and similar cases, physician education can be a boon for hospitals and health systems trying to reduce unnecessary out-of-network utilization.

In addition to reducing the overall cost of care, organizations can employ data to identify opportunities to increase revenue through premium enhancement and member management. Member risk scores are large drivers of premiums—organizations managing higher risk members demand higher rates from payers. When investigating its population, an organization may find that it receives disparate risk scores for members belonging to populations that overlap or are fairly similar. Rather than differences in acuity, this discrepancy may in fact be due to gaps in coding across members. Through analyses of the population and claims, the organization can identify and fill those gaps so that member acuity is more accurately reflected in the data. Furthermore, by undertaking regular review of member data, the organization can ensure that members are properly aligned to appropriate insurance products and ensure proper re-enrollment at the end of each cycle. For example, the organization may identify members above age 65 who are enrolled in Medicaid but not in Medicare. Getting these members properly enrolled in Medicare can often generate significant premium increases for the organization.

Claims data analysis can also contribute to an organization's performance improvement and quality processes. By diving into specific areas of operations, organizations can set targeted benchmarks for performance. Decision-support tools such as dashboards provide leaders with quick insight to their areas of focus. They allow for leaders to track KPIs over time as well a present an illustrative snapshot of their organization in real time. Setting target benchmarks can be done through both internal and peer-based performance.

Succeeding in today's pluralistic payment environment requires that hospitals and health systems be able to nimbly navigate the myriad of upside and downside risk arrangements, especially for those moving a significant portion of their book of business into dual-risk and capitation arrangements. Boards must engage in discussions to ensure proper alignment of mission and purpose to population health management strategies. Organizations that have invested wisely in their data capabilities will be well positioned to take on the challenges of population health management and downside risk contracts, enabling them to fulfill their community healthcare responsibilities and position themselves for long-term financial success.

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