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FROM CARE MANAGEMENT TO POPULATION HEALTH MANAGEMENT

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There is a massive shift underway from payer-based care management to population health management ***driven by providers.***

Population health management is definitely a hot topic in healthcare today, so I'm excited for the opportunity to weigh in on it by exploring the following:

- The evolution of population health management
- Data needs for effective population health management
- Population health business models
- Vendor solutions

I suspect folks in the "care management" segment of our market feel like this fuss about "population health management" is déjà vu all over again … so that seems a logical place to start this exploration.

The Old Care Management Market

If you've been kicking around the healthcare industry as long as I have, you're familiar with the term care management. Before the Affordable Care Act took the industry by storm, health insurance companies were the primary group who cared about managing the health of populations.

These payers cared a lot, because they had so much money on the line. They needed data-driven systems that could help identify and manage patients who might incur large healthcare expenses at some future time. The care management market was born out of this need.

Payer-led care management typically worked like this:

- Utilizing the data sources they had access to, payers would analyze the claims data for the populations of people whose health they insured.
- Insurers would notify employers if they had a lot of high-risk people.
- They deployed a variety of incentive programs to try to reduce the future cost of care for those patients. Company weight-loss contests, walk-a-thons and health club membership subsidies were typical examples of such programs.
- Care management systems would further target at-risk individuals by sending letters and faxes to doctors' offices suggesting they look into the possible gaps in care.
- The insurance companies built massive infrastructures of phone-based nurses who would call doctors and patients to alert them to potential issues and follow up to make sure the issue was being addressed.
- Everybody figured out that they needed the patients' participation in order to make all this work. So patient engagement capabilities like online health records and employee wellness portals were added to the mix.

> Providers need a population health management solution with extensive rules that will identify their at-risk populations, capture all known patient data from any possible sources, coordinate care, and engage patients directly in their own care.

Who paid for all these services? The employers. The logic behind this was, "If you invest in care management, you can reduce your overall healthcare spend."

Evolving to Something New

This entire market segment is under serious stress for three main reasons:

1. Healthcare data (claims) are typically retrospective in nature, often times one to three months delayed.
2. Data do not universally include the actual clinical information required for critical insight. At best, data are derived from claims, making a series of assumptions about the current patient status.
3. The big gains from this entire care management approach have plateaued.

So what's taking its place now? You'll hear it called different things. Accountable care. Population health management. Value-based care. What it comes down to is this: there is a massive shift underway from payer-based care management to population health management *driven by providers*.

Sources of Data for Population Health Management

Back in the day, managers of payer-driven care management systems had to answer the question, "Where am I going to get the data I need to identify high-risk patients and gaps in their care?" They had two potential sources:

Clinical data

This source may have seemed ideal, but unfortunately, it wasn't a viable option. Even if hospitals wanted to send clinical data to an insurance company—and they generally didn't—it wasn't feasible. The data was scattered across too many disconnected care settings. All of these players—hospitals, primary care physicians, pharmacies, specialists, reference labs and more—were working as independent and completely uncoordinated actors in managing patient care. In fact, most providers at the time had paper-based systems. The data was dispersed, hard to get at and sometimes nonexistent.

Claims data

Claims data proved to be the best option for these early systems. The payers used the systems, and they provided the data. These systems were built on the claims that providers sent to the insurance companies for payment under the fee-for-service business model.

So how good was the claims data? It had its good points:

- It was in a relatively standard format, making it easy to consume and make sense of.
- It was available! Doctors, hospitals, pharmacies, labs—in short, any healthcare provider who wanted to be paid—sent their data to the payers. That made for a pretty rich store of information.
- It had basic information describing a patient/member condition, which gave the care management systems clues about what was going on. For example, the care management system knew a patient had blood work done, but it didn't have the actual clinical data.

What wasn't good about claims data? Plenty.

- It was old and retrospective. Imagine waiting 60 days after a doctor's office visit before your system could alert the physician that an asthma patient hadn't filled the prescription for the inhaler.
- The data didn't include actual clinical information, and, as a result, the care management system made conjectures about actual patient clinical status, but that is never as good as having that actual clinical data.
- You could only infer so much from claims data, and eventually you had to look in the chart to really understand the patient disposition and begin to help doctors and hospitals manage their care.

Enter Real-time Clinical Data

So, where do we get the data to transform what is needed for population health management today? At Health Catalyst®, we use near real-time clinical data. What wasn't possible 10 or 15 years ago is possible today. EMR and Health information exchange (HIE) vendors have amassed real-time clinical data by connecting disparate doctors, hospitals, pharmacies and labs.

Integrating this data with retrospective claims data gives healthcare organizations a rich picture of their patients' or members' health. Exactly how to integrate this data and how best to use it is a challenge organizations are beginning to tackle today.

Why are Population Health Management Systems So Difficult to Tackle?

Plenty of things make tackling population health management seem difficult, but I'll focus on two factors in particular:

1. The adversarial payer/provider relationship
2. Technology that can really integrate

Payers and Providers on the Same Side?

Let's face it: payers and providers tend to butt heads. But in the world of accountable care, they need each other more than ever. Providers are beginning to take on risk for the management of their defined populations. For the most part, though, these providers have limited expertise around how to:

- Price the risk
- Manage the risk
- Create risk-based products that can get the blessing of state insurance regulators
- Set aside statutory capital necessary to fund care as it is required
- Pay all their provider participants in the new risk-based models
- Look out into their community and actively manage their population to the least expensive appropriate level of care
- Orchestrate and manage patient care as they navigate their way through the continuum of care providers in their community

For their part, insurance companies can't succeed without working closely with the individuals who are on the front lines delivering care. Many providers are looking to become insurance-like companies themselves. If insurers cannot partner with providers in the management of care, they run the risk of becoming irrelevant.

Insurance companies have the tools, the capital and the community infrastructure. Hospitals and doctors deliver the care. Many are deciding to transform their business relationship and become partners instead of adversaries. Both are starting to realize the complementary relationship that they have in delivering care while managing patient wellness.

This is a huge step forward, but there will still be bumps in the road. With over 90 percent of the actual healthcare spend in the country still based on the old fee-for-service model, the natural conflict between insurance companies and providers will linger.

Vendor-neutral Population Health Management

Providers need a population health management solution with extensive rules that will identify their at-risk populations, capture all known patient data from any possible sources, coordinate care, and engage patients directly in their own care. Many traditional HIT vendors see this as a great opportunity to transform themselves into population health management solutions. They want to become more than a data-capture and reporting tool.

But I strongly believe that only a vendor-neutral population health management solution can truly deliver what the market demands. Why? Because only a vendor-neutral company like Health Catalyst truly doesn't care which systems are sourcing the data.

A healthcare IT vendor with a competing product offering will always stumble when a hospital seeks to have a competitive system source its data. The pace of change will always outpace the ability of any one vendor to truly deliver all the solutions a newly at-risk population healthcare model will require.

As we look out 10 years into the future, the question in my mind is WHO that ultimate buyer of the vendor-neutral population health management solution will be:

- Hospitals and doctors only?
- Hospitals and doctors in partnership with insurance companies?
- Hospitals and doctors owned by insurance companies?

But a vendor-neutral population health management system that grabs all data from all sources without prejudice will be an absolute requirement.

Brent Dover has been the President of Health Catalyst since February 2013 and is responsible for all sales activities. Previously, Mr. Dover spent nearly 14 years at Medicity in various executive leadership positions including most recently as President. While there, he led the business growth that led to an Aetna acquisition in 2011. His experience during those years also includes various executive roles for Park City Solutions which merged with Medicity in 1999. Prior to that, Mr. Dover was Vice President of Sales at Eclipsys and at Sunquest Systems for a combined total of nearly eight years. Mr. Dover started his career at IBM. Spanning his career, Mr. Dover has been a strategic innovator driving solutions for healthcare organizations that were seeking operational and clinical efficiencies using cutting edge information technology.

Mr. Dover graduated with a BS in Systems Engineering from the University of Arizona.

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