POPULATION HEALTH PARTNERSHIPS TO ADVANCE VALUE-BASED CARE

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The business model for health care in the United States is evolving from a volume-driven model to a consumer-centric, value-driven model. As such, there are new competencies required of hospitals and health systems to effectively manage a population's health across the continuum of care. Many hospitals and health systems will need to partner with other organizations to gain the capabilities and efficiencies required to provide services under new care delivery and payment arrangements. This article discusses the why, what and how of creating and implementing a population health project with partners.

As health systems begin to take on financial risk, achieving improved outcomes depends on how successfully that system can deliver "the right care for the right patient at the right time." Unfortunately, providers often fall short of this goal, resulting in lost opportunity. Today's complex health care delivery and reimbursement environment requires providers and systems to enact more population health initiatives via partnerships that build on existing resources and tools. The Centers for Disease Control and Prevention (CDC) defines population health as "an interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally. This approach utilizes non-traditional partnerships among different sectors of the community—public health, industry, academia, health care, local government entities, etc.—to achieve positive health outcomes."[1] Standing alone trying to deliver high-value care is nearly impossible, not to mention wasteful. Systems, providers and leaders should start by understanding the why, what and how of population health as a foundation for high-value care delivery **(Figure 1)**.

It Starts With "Why"

When we enter the post-COVID environment, most health systems will be focused on enhancing revenue and reducing costs. Investments in population health outcomes will be especially challenging, so clear appreciation of why population health partnerships are important will be critical. In addition, leaders should identify and understand the specific reasons for why they need to enact such projects in their own community/region.

The foundation for the "why" can be drawn from insight via a community health needs assessment (CHNA). A CHNA is a systematic process involving the community to identify and analyze community health needs. The process provides a way for communities to prioritize health needs and to plan and act upon unmet community health needs. The Internal Revenue Service requires nonprofit hospitals to conduct a CHNA every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA.[2] The assessment identifies key health needs and issues through systematic, comprehensive data collection and analysis. As described by the CDC,[3] CHNAs use such principles as:

- Multisector collaborations that support shared ownership of all phases of community health improvement, including assessment, planning, investment, implementation and evaluation;
- Proactive, broad and diverse community engagement to improve results;

FIGURE 1: Successful components of population health projects.

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- A definition of community that encompasses both a significant enough area to allow for population-wide interventions and measurable results and includes a targeted focus to address disparities among subpopulations;
- Maximum transparency to improve community engagement and accountability;
- Use of evidence-based interventions and encouragement of innovative practices with thorough evaluation;
- Evaluation to inform a continuous improvement process; and
- Use of the highest-quality data pooled from and shared among diverse public and private sources.

Given that the ultimate described goal of a CHNA is to develop strategies to address the community's health needs and identified issues, the assessment findings can serve as the foundation for describing a value proposition for undertaking population health projects.

Finally, before providers or systems commit to action, they should also step back and cultivate an appreciation of the value of a model or partnership. This requires a true sense of a program's cost. Of note: Cost is beyond writing checks, as a health system's administrative burden is often more significant. Value is then assessed through balancing these total costs against the benefits in terms of the clinical and financial outcomes. All too often, health systems overestimate the benefits while underestimating the costs. This results in disappointment, which then leads to stalled action moving forward.

Population Health Projects

The "what" involves development and implementation of population health projects through partnerships. The elements of these projects involve identification and intervention. Identification requires identification of the right patient at the right time. Here, providers often miss the mark on timely identification. Patients are identified as high risk after the fact, at which point interventions to improve outcomes are difficult (if not impossible). Instead, focus and interventions should be aimed at "rising risk" patients, i.e., those not yet heavily utilizing services but who likely will be soon.

While there are many identification tools, sometimes the calculation process is too complex. Other tools are too delayed in their timeliness to be effective in practice. For an identification tool to be effective, it must have an easy calculation system and be available at the point and time of care.

One screening tool that can easily identify older populations who are at high risk for using health services heavily in the future is the Pra™ and PraPlus™ Screening Instrument.[4] These instruments are owned by Johns Hopkins University. The PraPlus is a 17-item questionnaire (the eight questions of the Pra, plus nine additional questions about medical conditions, functional ability, living circumstances, nutrition and depression). One of the most telling elements of this screener is a patient's self-assessment of their health status. While the PraPlus is an easy-to-use, timely screener, it does not point the user toward the needed intervention. A tool that screens based on specific intervention can accomplish that. For example, a series of rated questions for which a patient assesses their status from -5 to +5 in specific population health areas can easily direct providers to filling care gaps **(Box 1)**.

BOX 1: Self-identified population health patient gaps.

- Caregiver support
- Medication: ability to obtain and manage
- POLST/advance directive completeness
- Food: access to and consumption of healthy food
- Transportation: access to and use of transportation (eg, food and care appointments)
- Educational level/health literacy/problem-solving ability
- Income/finances to support healthy living
- Primary physician relationship (could be a specialist)

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This can also be done through simply asking hospitalized patients and/or their caregivers, "What do you need to keep safe at home?" These needs can then be filled through application of clinical pathways to carry out next steps in the care plan. Clinical pathways have done well in this area since their starting point in care is easily noted, often via a diagnosis/staging, and then an effective pathway prescribes the highest-value, most evidence-based next steps of care for that type of patient. But population health initiatives may be more complex in terms of factors they consider regarding the patient, such as social determinants of health and other external factors. Addressing all of these factors in a patient-centric approach requires modification of most current clinical pathways to be effective.

The Final Step: How

The perfect plan is nothing if not implemented well. Simply handing someone the ideal playbook is far from ensuring success. Effective implementation requires clear direction to all participants. Ideally, such instruction is provided by leaders in a health system that has already successfully completed implementation of these efforts, and their experience in overcoming challenges can be adapted to the new system. Piloting population health partnership projects can go a long way to ease implementation strains and ensure success.

> "This appreciation of the value requires examination of the costs and benefits, illustrating how to implement a plan by beginning with the end (ultimate goals) in mind."

Outcomes, Process, Structure

The Agency of Healthcare Research and Quality describes types of health care quality measures.[5] Measures used to assess and compare the quality of health care organizations are classified as either a structure, process or outcome measure. Known as the Donabedian model, this classification system was named after the physician and researcher who formulated it.[6] Effective implementation of a plan can be assessed by evaluating the structure, process and outcomes of a plan.

Structural measures (the "how" of a plan) reveal a health care provider's capacity, systems and processes to provide high-quality care. Process measures (the "what" of a plan) indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition. These measures typically reflect generally accepted recommendations for clinical practice, which can be articulated through high-quality clinical pathways, such as the exact process needed for patient identification, timing and intervention. Outcome measures (the "why" of a plan) reflect the impact of the health care service or intervention on the health status of patients—why the organization sought to implement the plan in the first place. This appreciation of the value requires examination of the costs and benefits, illustrating how to implement a plan by beginning with the end (ultimate goals) in mind.

This article was originally published in the *Journal of Clinical Pathways,* September 2020.

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