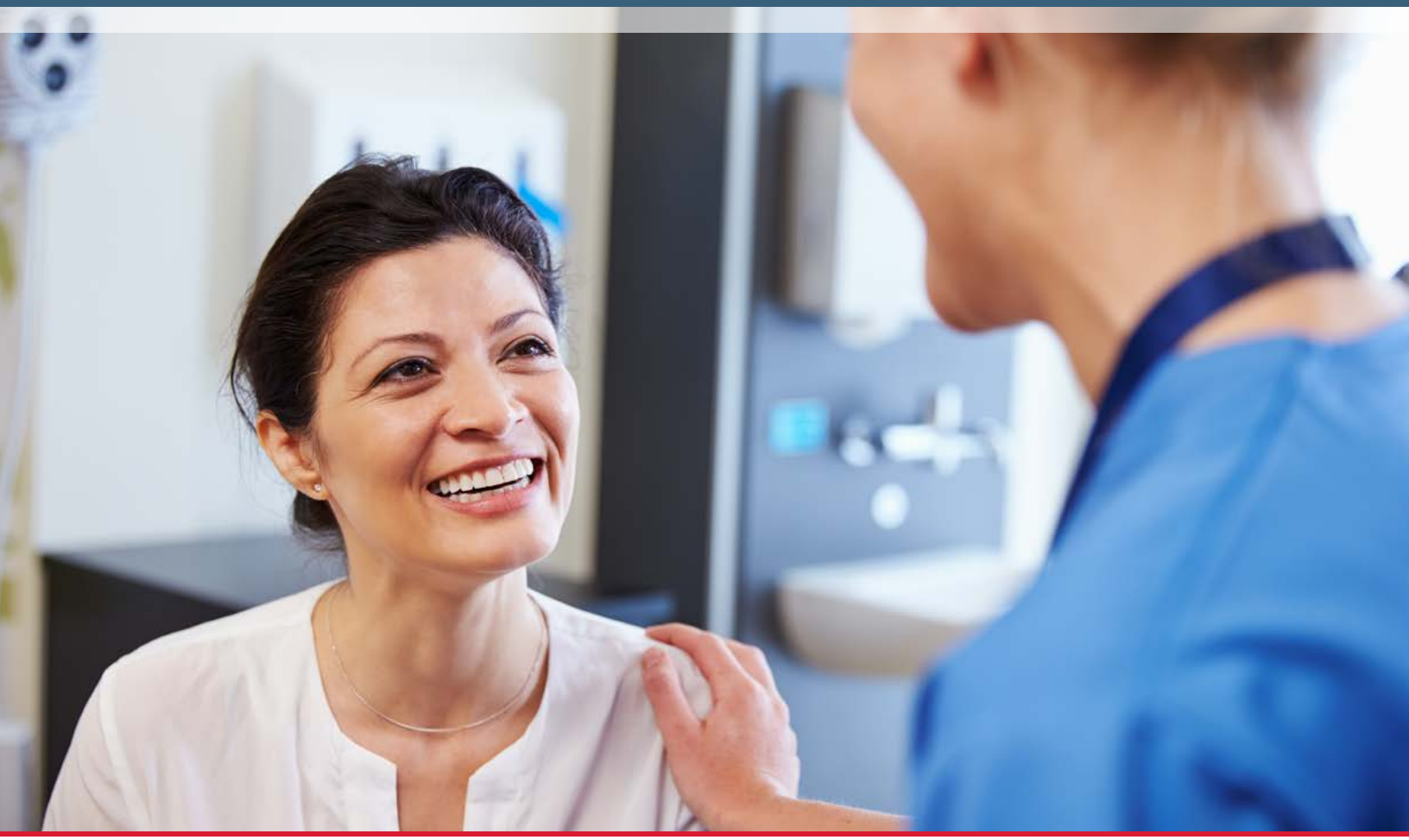
National Committee for Quality Assurance in Collaboration with Health Management Associates

Population Health Management: Meeting the Demand for Value-Based Care



HEALTH MANAGEMENT ASSOCIATES

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OVERVIEW

Over the last decade, federal, state and private sector activities have driven population health management and value-based care to the forefront of health care. Public purchasers, such as Medicare and state Medicaid programs, and employers have created incentives for health plans—and increasingly, provider organizations—to contain costs, improve health care quality and meet or exceed population health goals. Other factors, such as changing demographics and the increasing prevalence of chronic disease, are also driving adoption of population health management.

Development of a comprehensive population health management strategy is critical to an organization's ability to drive outcome improvements and succeed under value-based payment models. Organizations must be able to identify the needs of their populations through assessment, risk stratification and development of programs and services that are tailored to those needs.

The National Committee for Quality Assurance (NCQA) engaged Health Management Associates (HMA) to summarize the key factors driving population health management adoption among health care organizations, as well as recent population health management trends that are helping organizations succeed under value-based care arrangements.

Although this paper is written for leaders of health care organizations considering Population Health Program Accreditation, the information will be useful for any organization that wants to improve on its population health management program. Components of NCQA's Accreditation standards for population health management programs are also summarized.

Highlights

- **A Demand for Value in Health Care:** Increasing expectations by public purchasers, employers, health plans and consumers has resulted in a shift toward value-based payment arrangements in health care.
- **Effective Population Health Management Strategies Deliver Value:** Organizations that want to succeed under value-based arrangements must implement effective population health management strategies to improve consumers' experience and quality of care, lower health care costs and improve outcomes. Population health management helps maintain and improve the physical and psychosocial well-being of individuals and addresses health disparities through cost-effective, tailored health solutions.
- **Best Practices:** Effective population health management programs reflect rigorous industry standards and best practices for assessing population needs, integrating data, stratifying populations by risk, implementing targeted interventions, providing practitioner supports and measuring quality improvement.

NCQA ACCREDITATION FOR POPULATION HEALTH PROGRAMS

Over 30 years, NCQA has continued to grow as the premier evaluator of quality in health plans, practices and other care organizations. NCQA's Health Plan Accreditation standards began assessing health plans' comprehensive population health management strategies in 2018 to advance a population-wide focus on care management. Recognizing that organizations besides health plans also execute population health management, NCQA created Population Health Program Accreditation in 2019.

Population Health Program Accreditation is for organizations that manage a population on behalf of a payer, such as a health plan, state or employer. Health plans often contract with organizations to address the needs of specific populations defined by age, demographics or payer, or by chronic condition. Provider organizations, accountable care organizations (ACO), integrated delivery networks, health systems and other population health organizations that provide person-centered and population- or condition-specific care are eligible for this Accreditation.

NCQA's Population Health Program Accreditation requirements are derived from its model of population health management. Effective population health programs support a whole-person approach to care delivery and treatment and account for many factors, including social determinants of health (SDOH). NCQA evaluates organizations' population health programs against industry best practices to ensure that they apply a comprehensive, consistent and rigorous population health management model. NCQA Accreditation helps organizations win business, meet regulatory requirements and distinguish themselves from the competition.

NCQA Core Evaluation Areas

- **Program Description.** The organization describes its population health program, including its evidence base, and reviews and adopts new, relevant findings as they become available.
- **Population Assessment.** The organization assesses its population to identify the needs and characteristics.
- **Data Integration.** The organization collects and integrates data sources to conduct population health management activities.
- **Population Stratification.** The organization segments or stratifies the population into actionable categories for intervention.
- **Targeted Interventions.** The organization provides targeted interventions based on the individual's needs.
- **Practitioner Support.** The organization involves practitioners by providing them with relevant information.
- **Measurement and Quality Improvement.** The organization evaluates the effectiveness of the population health management programs.
- **Individuals' Rights and Responsibilities.** The organization communicates the individuals' rights and responsibilities.
- **Delegation of Population Health Program.** The organization monitors population health management activities it delegates to other organizations.

POPULATION HEALTH MANAGEMENT DEFINED

The concept of population health in the U.S. was defined in 2003 by leading public health researchers to mean "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[1] Other leaders and organizations have since expanded this definition by introducing important dimensions of physical and psychosocial well-being;[2] considerations of upstream factors such as health promotion, disease prevention and care coordination;[3] and a core emphasis on implementing data-driven strategies that identify the unique challenges and disparities affecting specific populations.[4]

Population health gained further national attention when Donald Berwick and colleagues at the Institute for Healthcare Improvement included "improving the health of populations" as one of the three elements of the Triple Aim. The Centers for Medicare & Medicaid Services (CMS), under Berwick's leadership, later adopted the Triple Aim as a strategy[5] to focus policymakers' attention on the simultaneous pursuit of improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care.[6]

Building on these contributions, NCQA defined population health management for its Accreditation programs:[7]

POPULATION HEALTH MANAGEMENT
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Population health management is a model of care that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for a defined population. The goal of population health management is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions.

Population Health Management Drivers

Over the last decade, federal, state and private sector activities have driven population health management and value-based care to the forefront of health care. Public purchasers, such as Medicare and state Medicaid programs, and employers have created new incentives for health plans—and increasingly, provider organizations—to contain costs, improve health care quality and meet population health goals. Other factors, such as changing demographics and the increasing prevalence of chronic disease, are also driving implementation of population health management.

Affordable Care Act

The Affordable Care Act (ACA), signed into law in 2010, addressed population health in four ways.[8] First, it improved access to the health care delivery system through expanded coverage, including state Medicaid expansions and subsidies available through health insurance exchanges. Second, it contained provisions to improve the quality of care delivered, including the National Strategy for Quality Improvement. Third, it sought to enhance prevention and health promotion efforts by putting new requirements on Medicare, state Medicaid programs and private health plans to cover certain preventive services and to promote creation of ACOs to incentivize providers to take responsibility for population health outcomes. Fourth, it promoted community and population-based activities, including the establishment of the National Prevention, Health Promotion and Public Health Council, as well as incentives for workplace wellness programs.

Medicare Quality Payment Program

Fundamental changes to how Medicare pays clinicians have further driven adoption of population health management initiatives. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 enabled CMS to reward high-value, high-quality Medicare providers through increased payments and to reduce payments to providers who do not meet performance standards.[9] In 2017, CMS launched the Medicare Quality Payment Program (QPP) to incentivize value of services. Under the QPP, clinicians can choose between two tracks (described below). Success in either track can be bolstered through implementation of population health management tools and solutions.[10]

MIPS. Under the Merit-Based Incentive Payment System (MIPS) track, performance is measured through data that clinicians report in four areas: quality; improvement activities (e.g., enhancing care coordination, patient and clinician shared decision making, expansion of practice access); promoting interoperability (e.g., use of EHRs and sharing health information); and cost.

APMs. The Advanced Alternative Payment Models (APM) track offers a 5 percent incentive to clinicians who accept some risk for patients' quality and cost outcomes and who meet other specified criteria. Under the QPP, an APM is defined as a customized payment approach designed to provide incentives to clinicians who deliver high-quality, high-value care. APMs can focus on specific clinical conditions, care episodes or populations. Advanced APM examples include the Bundled Payments for Care Improvement (BPCI) initiative, which links payments for the multiple services beneficiaries receive during a clinical episode of care. The Comprehensive Primary Care Plus (CPC+) program is an advanced primary care medical home model that aims to strengthen primary care through regionally based, multi-payer payment reform and care delivery transformation. Other APM examples include payment arrangements with downside risk[11] and ACO models.

Medicaid Programs

State Medicaid programs have increasingly focused on population health and implementing value-based, accountable care models to incentivize providers and organizations to move from exclusively fee-for-service based payment to shared risk and population-based payment models. As of July 2019, 39 states and the District of Columbia contracted with comprehensive, risk-based managed care plans to provide care to at least some Medicaid beneficiaries. Twenty-one states set a target percentage in their managed care contracts for provider payments, network providers or plan members who must be covered via APMs in fiscal year 2019—in fiscal year 2016 only 5 states did this.[12]

The increase in Medicaid APMs has been accompanied by an increase in Medicaid delivery system reforms. By the end of 2018, 13 states had implemented Medicaid ACO programs, up from 9 in 2016. While there are significantly more Medicare ACOs nationwide, Medicaid ACOs have two to three times as many lives per contract as Medicare and commercial ACOs.[13] This concentration gives Medicaid ACOs greater scale in their local markets. These data points demonstrate opportunities for leveraging population health management strategies among high-need, lower socioeconomic populations.

State Medicaid ACO models have shown signs of promise. A 2019 report by Leavitt Partners found that Colorado's ACO programs had a net savings of $77 million and decreased the rates of emergency department (ED) visits, high-cost imaging services and hospital readmissions.[14] Similarly, Minnesota's ACO program saved $213 million in four years and reduced hospital readmissions and ED visits by 14 percent and 7 percent, respectively.[15]

Employer Activities

Employers have also sought to contain their share of health care costs while investing in employee health and productivity. A 2015 survey of 120 large employers found that three-quarters of respondents believed that integrating primary care and population health management solutions into their health care offerings can produce beneficial results for their company and for employees.[16] Nearly two-thirds of employers in the survey offered lifestyle coaching to help with behavioral changes such as smoking cessation, a healthier diet or getting more exercise. A study by Rand Corporation found a nearly 30 percent reduction in hospital admissions among employees who already had a chronic disease and who participated in a disease management program.[17]

Changes in Demographics and Disease Prevalence

Other demographic and disease factors are also driving interest in population health management. The older adult population is expanding, living longer and experiencing multiple chronic conditions. The number of Americans 65 and older will more than double over the next 40 years, reaching 80 million in 2040.[18] Moreover, chronic conditions such as diabetes and high blood pressure increase with age. The National Council on Aging estimates that 92 percent of older adults have at least one chronic disease and 77 percent have at least two chronic diseases.[19]

Among all American adults, the prevalence of chronic disease and the number of people with multiple chronic conditions have increased markedly over the past two decades. In 2015, 18 percent of American adults were treated for five or more chronic diseases—in 1995, this figure was 8 percent.[20] Chronic disease prevalence also varies by race and ethnicity. Non-Hispanic Blacks are 55 percent more likely to be diabetic, 60 percent more likely to have high blood pressure and 56 percent more likely to have cerebrovascular disease than non-Hispanic Whites.[21] Some of the difference is associated with different rates of obesity between population groups: In 2014, 34.5 percent of non-Hispanic Whites were obese, 48 percent of non-Hispanic Blacks were obese and 43 percent of Hispanics of any race were obese.[22]

Chronic disease rates are a major driver of U.S. health care costs: Costs for chronic disease totaled $1.1 trillion in 2016.[23] Accounting for lost economic productivity, the total economic impact was $3.7 trillion, representing nearly 20 percent of the U.S. gross domestic product.

Global pandemics are another rising health concern for health care organizations. With the onset of the COVID-19 pandemic, health care organizations have tried to move quickly to build new capabilities to test, trace and manage individuals with or at risk for COVID-19, and to manage chronic conditions remotely for non-COVID patients.[24] While the end of the COVID-19 pandemic is uncertain, the spread of COVID and other diseases like Ebola, SARS, MERS and H1N1 demonstrates the demand for coordinated and nimble health care responses to contain future outbreaks.

Data Interoperability Standards

Lack of seamless data exchange in health care has historically detracted from patient care, leading to poor health outcomes and higher costs. Through federal regulations issued in 2020, CMS, in partnership with the Office of the National Coordinator for Health Information Technology (ONC), issued new rules to move the health care system toward greater interoperability and support the access, exchange and use of electronic health information. The 21st Century Cures Act final rule, issued by ONC, establishes the United States Core Data for Interoperability (USCDI), a standardized set of health data classes and component data elements for nationwide interoperable health information exchange.[25] Adoption of the USCDI will ensure utilization of common data and vocabulary code sets. Standardization will support both electronic exchange and usability of data for population health management.

The Interoperability and Patient Access final rule issued by CMS includes new policies covering CMS-regulated payers (Medicare Advantage, Medicaid, CHIP, Qualified Health Plan issuers on federally facilitated Exchanges) that give patients access to their health information, and moves the health care system toward greater interoperability. The rule includes policies on payer-to-payer data exchange, provider directory information, individuals' digital contact information and admission, discharge and transfer event notifications.[26]

ESSENTIAL COMPONENTS OF POPULATION HEALTH MANAGEMENT

Development of a comprehensive population health management strategy is critical to an organization's ability to drive outcome improvements and succeed under value-based payment models. Purchasers and health plans view population health management activities as essential to their ability to shift to value-based payment.[27] Organizations must be able to identify the needs of their populations through population assessment and risk stratification, and develop programs and services that are tailored to the needs of those populations. These programs are an essential component of an overall population health management strategy.

Data Integration

Integration of data across a broad spectrum of sources and systems is the first step in the process of population assessment, risk stratification and support of a comprehensive population health program. Organizations need timely and accurate information to provide individuals with the right supports at the right time. Data must be continually collected, refreshed and integrated to support population health management. Effective organizations adopt a broad data integration model that pulls a variety of data types from multiple sources to feed reporting and data-driven decision making.

The necessary data sources will vary, depending on the population served, and may include:

- Medical, behavioral, pharmacy and LTSS claims data.
- HR data.
- Data from care plans and care management systems.
- Screening and assessment results (including SDOH factors).
- Telemonitoring devices and technologies.
- Electronic visit verification system data.
- Data held by health information exchanges (e.g., facility-based admission, discharge, transfer notifications).
- Public immunization registries.
- Opioid prescription monitoring programs.
- Public agencies (e.g., child welfare, mental health, agencies serving individuals with intellectual and developmental disabilities).
- Community-based and human-service organizations.
- Other third-party subcontractors.

The increase in data and data sources results in an increasingly complex data integration environment that includes regulatory requirements, organizational collaborations, data transfer elements, normalization models[28] and aggregation solutions to support the expanded strategy. Long-standing barriers to collaboration require careful evaluation to establish links in purpose, philosophy and goals between communities, public health, providers, payers and others, all of which share the goal of population health improvement.[29] Moreover, the increase in electronic data has deepened the depth and complexity of implementing effective population health analytics.

Despite the challenges associated with data integration, the opportunities to provide meaningful and actionable information to providers, care managers and the broader audience of supports and entities can have a direct impact on population health outcomes. One successful example of a collaborative model is the Health Improvement Partnership (HIP) of Santa Cruz County.

The local health system was highly disjointed because there was no single influential payer, county hospital or other large organization in the community driving a comprehensive health improvement strategy. The HIP collaboration brought local health care organizations together and focused on three interconnected areas: building systems of care, strengthening the safety net and promoting collaboration. The organizations shared data, including hospitalizations for ambulatory care-sensitive conditions, avoidable ED use, patients switching practices, primary care visits and Healthcare Effectiveness Data and Information Set (HEDIS®)* measures. This fueled a significant focus on patient-centered medical homes and sharing of best practices among community providers. The HIP collaboration resulted in a reduction in ED use among infants by 29 percent and an increase in clinic capacity by 10 percent.[30]

Understanding the Population

Establishing a comprehensive, population-focused assessment model is vital to improving health outcomes. Critical differences exist between the Medicare, Medicaid, commercial and uninsured populations. It is necessary to apply a nuanced model of population health assessment based on the population of focus and to develop reports that empower a deeper understanding of the risks, needs and health improvement initiatives needed for specific subpopulations. For example, Medicaid covers many subpopulations, including nearly half of all births in a typical state (and many more, in some states), as well as over 80 percent of poor children, nearly 50 percent of children with special health care needs and about 45 percent of nonelderly adults with disabilities.[31]

Population health management models must account for key differences in demographics and health care needs across subpopulations when developing assessment requirements, engagement models and health promotion initiatives.

By way of illustration, Medical Home Network (MHN), in Illinois, with support from the Illinois Department of Healthcare and Family Services, launched a value-based payment model in an integrated delivery system. MHN reduced the total cost of care trend for 170,000 attributed lives by 3.5 percent in year one and by 5 percent in year two.[32] The pilot's success led to the launch of an integrated delivery network connecting over 300 separate entities. MHN was able to accomplish these results in part by achieving an 82 percent completion rate for health assessments, compared to rates well below 50 percent for comparable organizations. To understand the risks and needs of the population, MHN integrated health assessment results with data from other sources (e.g., claims data, admission/discharge data) into a centralized analytic platform. This allowed MHN to focus its population health management strategy and apply prioritized, real-time alerts sent to delegated care managers at the practice level.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Sharing data across organizations promotes deeper understanding of the issues that affect a population. For example, a care manager may conduct a health risk screening and identify lack of transportation as a significant issue, but the individual's primary care provider may not know that this is the reason for several no-show visits. Sharing data across entities—and especially in a value-based payment model—is required for management of a population's complex needs.

SPOTLIGHT:

Using Social Determinants of Health to Understand a Population

Research shows that over 60 percent of health and longevity is driven by nonclinical factors. Policymakers and health care organizations are increasingly interested in understanding social determinants of health (SDOH)—the conditions in which people are born, grow, live, work and age—which include socioeconomic status, education, neighborhood and physical environment, employment, social support networks and access to health care.[34]

Because of the emerging emphasis on SDOH, the number of related data elements collected has increased to assess SDOH impact on population health. Several federal and state initiatives have supported a focus on SDOH; for example, the Center for Medicare and Medicaid Innovation has supported multi-payer delivery and payment reform models that include a focus on population health and the role of social determinants.[35]

Challenges to addressing SDOH include a lack of concise assessment models and insufficient medical research focusing on diverse patient cohorts with social health challenges. Although there are a variety of SDOH screening tools, many lack clear links to evidence-based studies. In addition, although providers recognize the need to evaluate social determinants in relation to health status, many lack the time and resources required to gather and apply this information.[36]

Some states, such as North Carolina, have established a standardized SDOH screening tool and a system to identify and assist individuals with unmet health-related resource needs.[37] The United States Preventive Services Task Force compiled a set of recommendations for application of screening tools.[38] Massachusetts created ACO certification standards that include a focus on risk stratification models and programs to address identified needs regarding behavioral health and SDOH.[39]

Population Stratification

Historically, payers have sought to segment and stratify populations; for example, to identify individuals with certain diagnoses or who are expected to be high users of services. Stratification enables creation of population cohorts for a variety of purposes, including for developing focused outreach and engagement campaigns, assigning patients to care management programs and for targeted interventions.

Claims-based risk stratification (using data on health care claims submitted by providers) has been the dominant approach because data are accessible to payers. Hierarchical algorithms combine a person's demographics and diagnoses to determine a "risk score." Risk scores can be "rolled up" from the person level to a population level. A higher risk score denotes a person or population with more health conditions or service needs that will result in health care spending. Medicare's Hierarchical Condition Category score captures how costly a person is anticipated to be, relative to all other beneficiaries.** In the commercial health insurance market, the number of widely available risk models grew from 12 models in 2007 to more than 40 in 2016;[40] however, each model can be applied for different purposes, from retrospective evaluation of concurrent risk to prospective evaluation of anticipated risk.

While claims-based risk stratification is a starting point, many population health management models include other clinical, socioeconomic and social-risk data to inform their stratification model, including information collected through screening and assessment processes. Examples of non-claims-based risk adjustment variables include markers for unstable housing, disability status, relationship or enrollment in a state agency/program; a "neighborhood stress score" that measures economic stress by census block group;[41] and social isolation. Other population health management stratification metrics include Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), which assess how well an individual can live on their own, independently. Difficulty with ADLs and IADLs often corresponds to how much help, supervision and hands-on care an older person needs. This can determine the cost of care at a facility, whether someone is considered "safe" to live at home or even whether a person is eligible for certain long-term care services.[42]

Population stratification leverages real-time data as much as possible. For example, information on facility-based admissions and discharges and other automated data feeds can be used to continually update risk stratification for a population.[43] CMS is modifying Conditions of Participation to require hospitals to send electronic notifications of a patient's admission, discharge and/or transfer to another health care facility or to another community provider or practitioner.[44]

Advancements in artificial intelligence models for health care are empowering organizations to have a more fluid, faster model for reporting and turning data into actionable information. One potentially significant advancement is the contrast between predictive and prescriptive models.[45] Many providers, care managers, health educators and others are already familiar with detailed predictive reports identifying specific populations of focus, with broad actions based on the anticipated risk patterns of the subset population. However, a more targeted interventional approach that uses a prescriptive model could support front-line workers by recommending a specific action—the one most likely to result in an outcome that would benefit the individual most.

A ***predictive model*** may identify a group of individuals with a high risk of readmission within the next 30 days, yet give little information about interventions that could prevent readmission. By contrast, a ***prescriptive model***, empowered by artificial intelligence modeling, would present recommended actions; for example, a phone call post-discharge, a medication reconciliation outreach call or a home health provider visit.[46] Empowering outreach and engagement staff with specific interventions—not simply with risk modeling and segmentation reports—is critical for driving a successful population health program.

** Hierarchical Condition Category (HCC) scores are recalibrated by CMS each year so the national HCC risk score = 1.0. A risk score of >1.0 in Connecticut assumes that its average morbidity is higher than the national average. A risk score <1.0 assumes Connecticut's average morbidity is lower than the national average.

Targeted Interventions

Application of a person-centered interventional model is a key success factor for improving health outcomes. Population health programs must put people at the center of all activities and care decisions; therefore, a successful program must turn data, insights and population segments into targeted, evidenced-based interventions to support the population.

Wellness and prevention services are one element of a targeted interventional model and can include online or onsite educational activities, preventive care reminders, personal coaching and self-management tools. An effective population health management strategy focuses on engaging individuals to identify those who are more likely to use high-cost care or develop a chronic condition.[47]

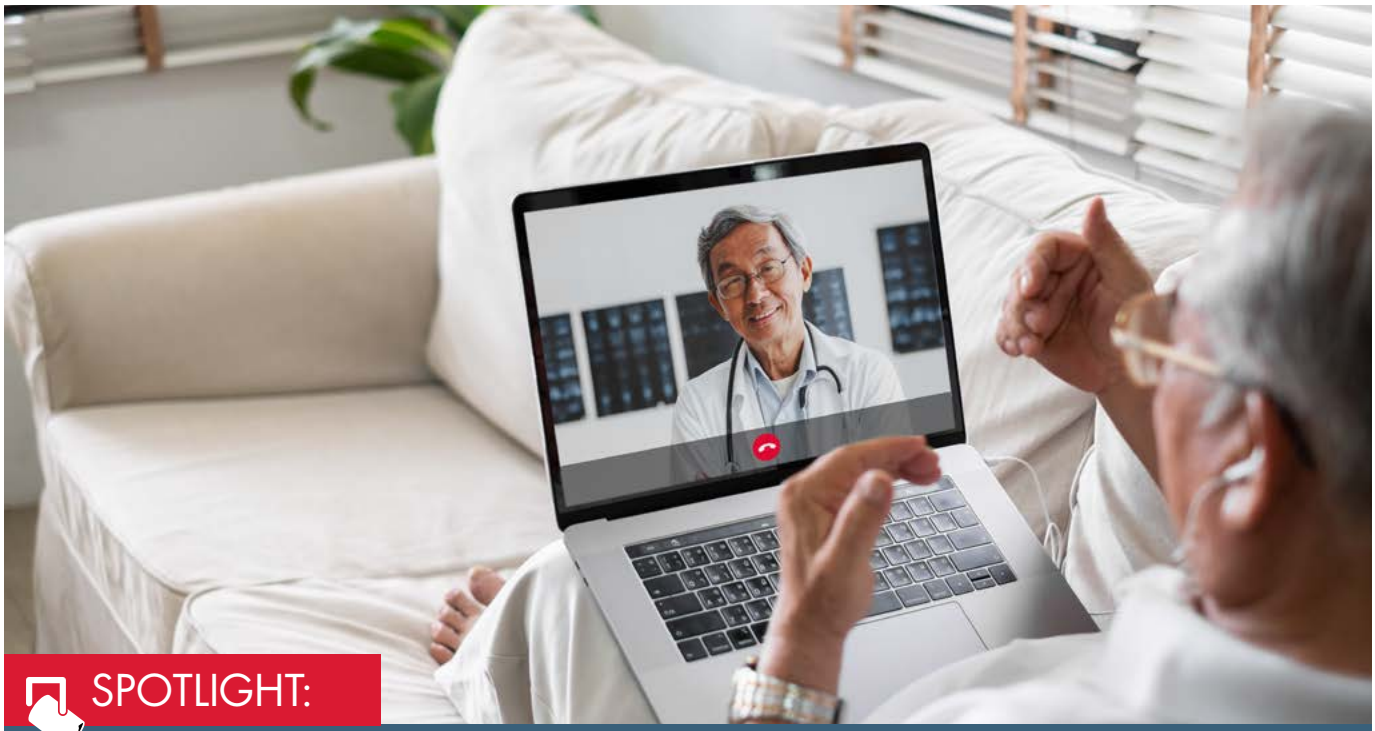
CMS promotes prevention in Medicaid and CHIP programs across many areas, including initiatives for school-based health, antipsychotic drug use in children, diabetes, HIV health improvement, tobacco cessation, obesity and oral health.[48] The agency's Maternal and Infant Health Initiative focuses on the rate of postpartum care visits, enhanced prenatal care programs, expanded data links for maternal and infant health records, and piloted the effectiveness of text messages to provide pregnant women and new mothers with health information and local resources.[49]

Evidenced-based targeted interventions also include a variety of care coordination and care management activities that are appropriate to the needs of a population. Activities often include ongoing telephone or in-person contact and support by a care manager or coordinator who ensures that an individual's clinical, behavioral, functional and social support needs are assessed; that a person-centered care plan is developed based on an individual's needs and prioritized goals; and that the services described in the care plan are being delivered. Care managers also help track how a care plan helps an individual make progress toward goals. Additionally, care managers and other members of a care team often help with coordination and follow-up across transitions in care, provide self-management support and education and quickly identify changes in a person's condition or circumstances that necessitate a change in the care plan.

One example of a population health initiative using targeted interventions to drive improvement was the landmark Diabetes Prevention Program sponsored by the National Institute of Diabetes and Digestive and Kidney Diseases. The intervention involved a lifestyle change program focusing on calorie reduction and increasing physical activity to at least 150 minutes per week. Care managers met with each participant for at least 16 sessions in the first 24 weeks and then at least every other month individually or in groups.[50] Ten-year follow-up results showed that participants were still one-third less likely to develop type 2 diabetes a decade later, and those who did develop diabetes delayed the onset by about 4 years.[51]

Other research also points to the effectiveness of population health management interventions among Medicaid-eligible children. A 2019 study of population health outcomes among Medicaid-eligible children exposed to an integrated population health management program in an academic pediatric health system found that children in the program experienced a reduction of 0.39 monthly admissions and 2.20 monthly bed days per 1,000 children.[52]

Another example involves a Medicare Advantage plan that developed personalized interactions using data and technologies to increase health assessment completion, health screenings, exam scheduling and reminders, post discharge support and member surveys. Results included a 46 percent increase in health assessment completion, an 83 percent increase in annual plan survey completion, an 80 percent increase in post-discharge support and a 38 percent decrease in readmissions. The plan's Medicare "Star Rating" also increased by half a star.[53]



SPOTLIGHT:

Population Health Interventions in the Era of COVID-19

The COVID-19 public health crisis has underscored the need for health care organizations to embrace more robust population health management interventions. Providers have adjusted their model of care to include technology and services that were previously underutilized—often due to regulatory barriers and unmet infrastructure needs—to ensure that health needs are being met. Remote treatment, telehealth and telemonitoring health promotion and prevention models have a direct impact on health and well-being. A recent survey revealed that the percentage of patients who used telehealth increased from 11 percent in 2019 to 76 percent in 2020.[54]

Payers have adapted their population health management strategy as well, particularly in addressing members' SDOH. For example, many payers expanded support for virtual access to care and telehealth, changes which many believe will remain after the COVID-19 crisis abates. Some payers also sought to address food insecurity by shifting medical transportation vehicles to deliver food to individuals with food insecurity. Transportation, housing and employment support models have also necessitated new methods to meet community needs. Organizations have developed dashboards to evaluate population health trends related to COVID-19 and to identify and support individuals at higher risk for the virus. There is unprecedented urgency for data and reporting, and organizations have scrambled to adjust their population health management strategies during the crisis.[55]

Practitioner Support

Population health programs rely on strong partnerships with practitioners responsible for providing care and coordination of services needed to support a population. Data sharing can give practitioners access to outside care visits (e.g., to a specialist), as well as to other scheduling and patient summary data. For example, claims data can be used to identify individuals who are eligible for, but have not had, routine screenings, well-child visits and other preventive health services. Predictive analytics can make practitioners aware of patients at highest risk of being admitted or readmitted. Practitioners can also see what is driving the total cost of care and make changes to treatment, if appropriate.

In addition to data sharing and advanced analytics, practitioners can be supported through onsite training or coaching, embedded care managers and community health workers, technical assistance and financial support.

Measurement and Quality Improvement

The increase in value-based care models has expanded the need for measurement approaches that align with population health management objectives and priorities. A focus on the quality, access and experience of care, as well as on cost and utilization, is the core of measurement and reporting. A disciplined approach to drive improved population health outcomes requires a diligent model for measuring the change in health outcomes based on a defined set of interventions. One health plan applied a Lean Six Sigma training program to employees for a health improvement initiative. Lean Six Sigma combines Six Sigma's 5-step "Define, Measure, Analyze, Improve, and Control" method with tools for process improvements. Staff applied this methodical approach to measure a baseline, identify key interventions to apply, analyze results and drive process improvement. Its objective was supporting patient engagement and health behavior change to facilitate enhanced health coaching in a primary care medical home in a large integrated delivery system. In the pilot, quit rates for tobacco cessation and success rates for weight management improved due to the enhanced engagement and coaching, resulting in an expanded focus on the model across a larger health plan population.[56]

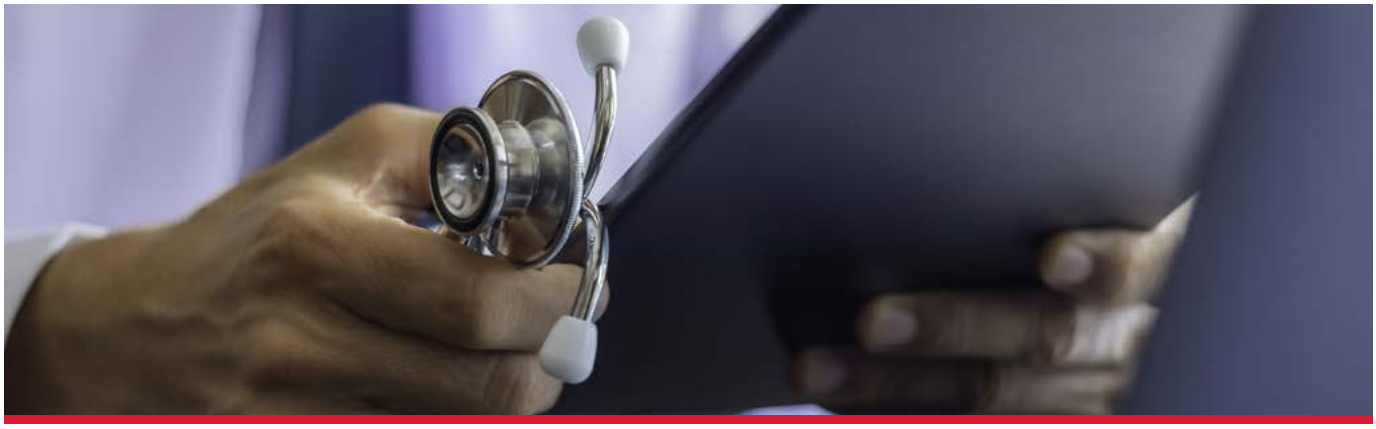
Meaningful, quantitative health outcome measures are a hallmark of health care analytics, but it is vital to incorporate a robust, yet stringent, method for establishing annual benchmarks and goals and for evaluating outcomes relative to those goals. Identifying and maintaining best practices that drive results to meet and exceed goals can help sustain outcomes over time. It is also important to identify organizational barriers to success and engage executive leadership in helping to overcome them.

LOOKING AHEAD

Federal, state and private sector demands for cost containment, better health care quality and improved population health outcomes are likely to grow louder as the nation's demographics and disease prevalence trends point to additional strain on public and private resources. Health care organizations' ability to drive outcome improvements and succeed under value-based payment arrangements will be tied to their ability to develop and execute comprehensive population health management programs.

As additional data sources emerge, analytic capabilities expand and data elements are standardized, health care organizations' ability to assess and understand population health needs will become more sophisticated. Further data integration and data sharing collaborations will unlock insights into meeting the needs of populations, especially complex populations that often receive services across a wide continuum of care. Advancements in predictive analytics and technologies will also help health care organizations and practitioners deploy targeted, evidence-based interventions, including interventions that address SDOH needs. Rigorous measurement will inform continuous quality improvement efforts as new needs emerge over time.

The global crisis brought on by the COVID-19 pandemic will add to the use of population health management capabilities. Health plans, provider organizations, ACOs and other population health companies may be increasingly called on to test, trace and manage individuals with or at risk for COVID-19, and to manage chronic conditions remotely for non-COVID patients, when possible. Use of telehealth modalities and telemonitoring is likely to remain a key component of the overall health care landscape, in part because virtual and near-virtual health solutions increase convenience for health care consumers. As advancements are made in treating and preventing COVID-19 (e.g., if a vaccine becomes available), population health management will likely play an essential role in identifying, prioritizing and treating individuals most at risk.



About NCQA

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 (ncqa.org) contains information to help consumers, employers and others make more-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.

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