Making population health work for small practices

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The specialized IT applications required for population health management are generally too expensive and complex for small, independent practices. So some physicians may reject this approach, which can improve outcomes and prepare practices for value-based reimbursement.

Nevertheless, it is possible to assemble the jigsaw puzzle of population health management—a care delivery model that emphasizes the overall health of a patient population, not just what happens in office visits—without overburdening a practice financially. Some groups have joined accountable care organizations (ACOs) or other kinds of networks to spread out the costs of the required infrastructure.

“Part of the reason we’re doing this is because the payment policy is changing,” says Matthew Callaway, MD, a co-founder of SAMA Healthcare Services, a primary care practice in El Dorado, Arkansas, that is engaged in population health management. “We have to do something to stay on top of the wave as far as payment models go. Hopefully, we’ll not only stay solvent as a practice, but we’ll also have better patient outcomes.”

Starting down the path
Independent practices must ultimately band together to manage population health effectively, experts agree. Yet there are things they can do to start down this path on their own. By improving their quality scores and their care coordination, these modest initiatives can help practices succeed in government programs such as the Merit-based Incentive
Payment System (MIPS) and the Comprehensive Primary Care Plus (CPC+) program for patient-centered medical homes.

First, practices should use their electronic health record (EHR) to the greatest possible extent and make sure they’re applying all the functionality and the data fields in the system, advises Michael Barr, MD, MBA, executive vice president, quality measurement and research group, for the National Committee on Quality Assurance (NCQA).

Even without any external data, he notes, practices can use their clinical and administrative data to identify many of their patients’ care gaps and have staff members contact those who need to come in for preventive care or treatment of chronic conditions.

If practices decide to acquire population health management tools, Barr says, they should pick applications that best support their goals and match their resources. For example, if a practice has the resources to do patient outreach and needs to identify the patients who have care gaps, they should look for a dashboard-type application for that supports that kind of activity.

“If they have no outreach people, but they have a patient portal, they might look for a solution that has a strong patient engagement piece that can be used with that portal,” Barr suggests.

David Nash, MD, dean of the school of population health at Thomas Jefferson University in Philadelphia, says that a handful of population health management applications can be used in small and medium-sized practices. Most third party software, however, is designed and priced for large organizations, he says.

Nash recommends that practices interested in full-scale population health management join some kind of larger organization, such as an ACO or a clinically integrated network. There are also online courses on this care delivery model from Thomas Jefferson University and the American Association of Physician Leaders, he says.
If a practice buys a population health management application designed to work with EHRs, he advises, “Tinker and get experience and see how it’s working, and begin the self-evaluation that’s necessary to effectively use the tool.”

**Core software requirements**

The core domains of population health management are care management of high-risk patients, disease management to slow chronic disease progression and utilization management to control costs. To perform these functions, practices need the clinical data in EHRs, additional data from outside the practice, analytic tools to target practice resources where they will be most effective and software focused on care management, patient engagement and performance measurement.

EHRs are at the center of these efforts, because they provide most of the data and the clinical workflow that physicians and practice staff use every day. But despite the recent efforts of EHR vendors to expand into population health management, experts say, systems still don’t support many of the key functions that this new approach to care delivery requires.

Farzad Mostashari, MD, the chief executive officer of Aledade, a company that manages 16 small primary care ACOs, says he thought that EHRs were going to be population health tools when he was National Coordinator of Health IT. However, Mostashari says he realizes now that these are not population health tools, and that another layer of information technology is needed above multiple EHRs in ACOs. Most major EHR developers offer population health modules as add-ons. Some of these vendors, Barr notes, have obtained the National Committee for Quality Assurance (NCQA) “pre-validation” of their population health management modules. Under this program, applicants receive credits toward medical home recognition from NCQA for using these applications.
But Leah Kaufman, the organization’s external relations manager for recognition programs policy and resources, says that “a lot of EHRs don’t have the functionality necessary to identify high-risk populations and to implement evidence-based decision support and point of care reminders. So many practices are looking at [third-party] population health solutions that will interface with their EHR.”

**Workflow changes**

Health IT plays only a supporting role in the care redesign that has to occur in practices to manage population health effectively.

“Even if you had the best software in the world, that would be only 20% of what’s needed for population health management. Eighty percent is going to come from configuration, implementation and internal workflow and training,” says Holly Miller, MD, chief medical officer of MedAllies, a company that supports the use of Direct secure messaging nationally and does practice transformation work in New York, New Jersey and Delaware.

For example, practices must hire the appropriate staff and make process changes to accomplish routine population health management tasks such as calling patients about follow-up care and tracking referrals. They must also learn how to use care managers to work with high-risk patients, how to identify those patients, how to improve transitions of care and how to manage care between visits. And most important for the bottom line, they must provide feedback to providers about their performance.

It is probably not possible to tackle all of these challenges at once. But by taking one step at a time and making good use of their EHRs, some of these groups have gotten to the point where they can use population health management software and have figured out a way to finance it.

**Government funding**
SAMA Healthcare used Medicare’s CPC demonstration project to fund much of its infrastructure for population health management. Under CPC, SAMA formed care teams and received monthly care coordination payments from multiple payers, including Medicare. The practice used that money to hire care coordinators and to transform itself into a patient-centered medical home.

SAMA’s EHR vendor developed a referral management system, and added features to categorize patients by their health risks and identify care gaps. (As a beta site, SAMA helped the vendor develop these features.) However, the EHR did not provide the actionable, patient-level data that SAMA needed for population health management. The group obtained access to that data only after it joined an ACO that had its own population health management software.

Pete Atkinson, MHA, administrator of the SAMA clinic, says that the group had a choice between buying a population health suite from their EHR vendor or using the ACO’s proprietary software. The practice’s EHR already had some of the functions that SAMA needed, such as referral management. SAMA picked the ACO partly because it had access to claims data from payers and because its application was much easier to use.

**How the software helps**

The ACO’s population health management software, which analyzes community EHR and claims data, allows care coordinators to examine information on any patient. For example, the software can identify how many times the patient has filled a particular prescription, how many times she has seen a particular doctor outside the practice, how many times she has gone to the emergency department, and what all of that costs, Callaway says.
With this kind of data in hand, he adds, “We can isolate that high-spend group [of patients] and get them in and discuss with them how can we improve these processes to keep them out of the ER and the hospital, and it’s actually working.”

The group’s readmission rates are low compared to the national average, Callaway notes. Aided by the software, the care coordinators follow up with patients after their hospital discharges and make sure their medication lists are correct. He also cites the example of a patient with COPD who did not receive an oxygen tank after being discharged from the hospital, but got one after a care coordinator contacted him.

The dashboard on the ACO's web portal tells the care coordinators who they need to call each day and allows them to set up reminders for weekly or monthly calls, says Atkinson. The software shows which patients are coming into the office, who they’re seeing, and whether they should be considered for care management, he says. In weekly care team huddles, the care coordinators tell the providers what they need to know about these patients.

Because the population health management application is not integrated with the group’s EHR, the care coordinators have to go to the ACO’s website to use it. That isn’t a problem for them, because they all have dual screens showing the population health management software and the EHR, notes Atkinson. But Callaway and his colleagues don’t have the time to go to the website when they’re seeing patients.

“We hope that in the future, our ACO might work with our EHR vendor to incorporate it into a one-view screen in the EHR,” Callaway says.