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# Managing Population Health

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According to the Institute of Medicine (IOM), the U.S. health care system wastes an astounding $750 billion annually.[1] By comparison, for the past several years the annual amount spent by the federal government has been roughly $800 billion on defense and $100 billion on education.[2] The need, and indeed the opportunity, for savings is immense. However, this is not an easy task due to a multitude of players in the health care industry who have competing interests. One solution that promises to help all players find common ground and achieve improved quality and reduced spending is "population health." But what is population health and how does it fit into optimizing health care performance?

## WHAT IS POPULATION HEALTH?

One of the most quoted definitions is from Kindig and Stoddart, who defined population health as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[3] This definition is actually quite complex as it requires an understanding of health outcomes and a distribution of those outcomes.

An alternative definition, and one that may be more applicable to this article (and population health in general) can be derived from the basic definitions of health and population. The World Health Organization (WHO) refers to "health" as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[4] This definition is not without controversy, as some may question if the term "complete" should be included in the definition, but the definition suits the purpose of this article. "Population" is simply the sum of all the people within a group. Consequently, "population health" can be defined as "a term referring to the physical, mental, and/or social well-being of a group of people."

How the term is used depends on one's point of view. As the head of a household, one may view population health as the well-being of those within one's home. A physician may view population health as the group of patients in his/her care. A government may view population health in the context of the well-being of those in a given neighborhood, state or country. This article focuses on the points of view of physician groups, health systems, and insurance companies or payer organizations.

Population health management (PHM) is a broad approach for addressing the health care needs of a specific population. Its goal is to keep a selected population as healthy as possible, minimizing expensive interventions. As health care information technology (IT) becomes more integrated, it is becoming possible to create registries that identify at-risk patients. Once these patients are identified, physicians can develop treatment plans for each patient and communicate with patients on an ongoing basis to encourage them to follow their treatment plans.

The adoption of PHM is happening in the context of a shift in risk from payers/insurers to providers/physicians, calling for a transition from fee-for-service to value-based care. In a fee-for-service world, physicians traditionally think about individual patients who are actively seeking or needing care. In a value-based environment, physicians must shift their thinking to the entire population they are responsible for, even if those in their patient panel are not actively seeking care. In order to be successful, value-based care requires a collaborative relationship between payers and providers and aligned incentive payments that reward outcomes, not the number of performed procedures.

## TRIPLE AIM (+1)

The Institute for Healthcare Improvement (IHI) developed the "Triple Aim" framework to describe an approach to optimizing health system performance.[5] The Triple Aim framework is the simultaneous pursuit of three dimensions of health care:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Each of these aims clearly has merit. However, are they mutually exclusive? For example, if a health care system decides to improve the patient experience by reducing wait times and, as a result, expands its facilities and services, does it end up actually increasing costs? Or, does the desire for a health plan to lower costs by offering a narrow network product diminish the patient's experience due to limited access to care?

These questions point to one of the main challenges in the simultaneous pursuit of these three dimensions, which is the fact that no one entity or person can accomplish all three. Only by working collaboratively can players in the health care delivery chain have the capacity to impact all three dimensions simultaneously. Within this delivery chain, it is important to recognize the critical role of primary care providers (PCPs) in establishing successful accountable care throughout the delivery chain.

The PCP is, in most cases, the entry point for patients into the health care system. The PCP does not work in a vacuum, though. The care for a patient may include interactions with facilities, specialists, nurses, numerous other health care professionals and payers. It goes without saying that this care must be coordinated. This places a large amount of responsibility on the PCP who must be fully engaged in order to meet the three aims. Thus a fourth aim, the "+1," that should be addressed is "improving physician satisfaction."

So, what is needed for the simultaneous achievement of these *four* aims?

First, enabling technology must be available to all players in the health care delivery chain that combines claims data with clinical (EMR) data. This allows for identification of gaps in care and identification of inefficient or ineffective use of resources. Additionally, this improves research into more effective clinical practice guidelines and the development of provider decision support tools.

Second, incentives should be aligned for patients, providers and payers. Value-based contracts, in particular, should be designed in order to share the appropriate level of risks and rewards between physician providers, facility providers and payers. Fortunately, there is movement in this direction. For example, the Department of Health and Human Services (HHS) has set a goal of tying 50 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as accountable care organizations (ACOs) or bundled payment arrangements by the end of 2018.[6]

Third, physicians must have sufficient panel density and meaningful compensation that is tied to measurable goals that benefit the patient, provider and payer. If the panel size is too small then the incentive to change behavior will be too small. Additionally, organizations should ensure compensation appropriately cascades to the PCPs, given their central role in achieving the four aims.

> The goal of population health management (PHM) is to keep a selected population as healthy as possible, minimizing expensive interventions.

Finally, physician organizations should have the appropriate organization and leadership structure in order to drive physician engagement and motivate process and behavioral change as necessary.

## CONCLUSION

The transition to population health management requires a shift in behavior for both payers and providers. It also requires a different understanding of the value of health care outcomes, which can be enhanced by an actuarial perspective. Our role includes providing decision support information and tools to physicians such that they make informed decisions. Actuaries can help health care organizations transitioning to value-based models by analyzing contracts and the financial and risk analysis of those contracts. By making information about cost and care metrics more transparent to physicians, and providers in general, and by equipping them with the right data and tools, we can help eliminate a tremendous amount of waste in health care spending overall. ■

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### ENDNOTES


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