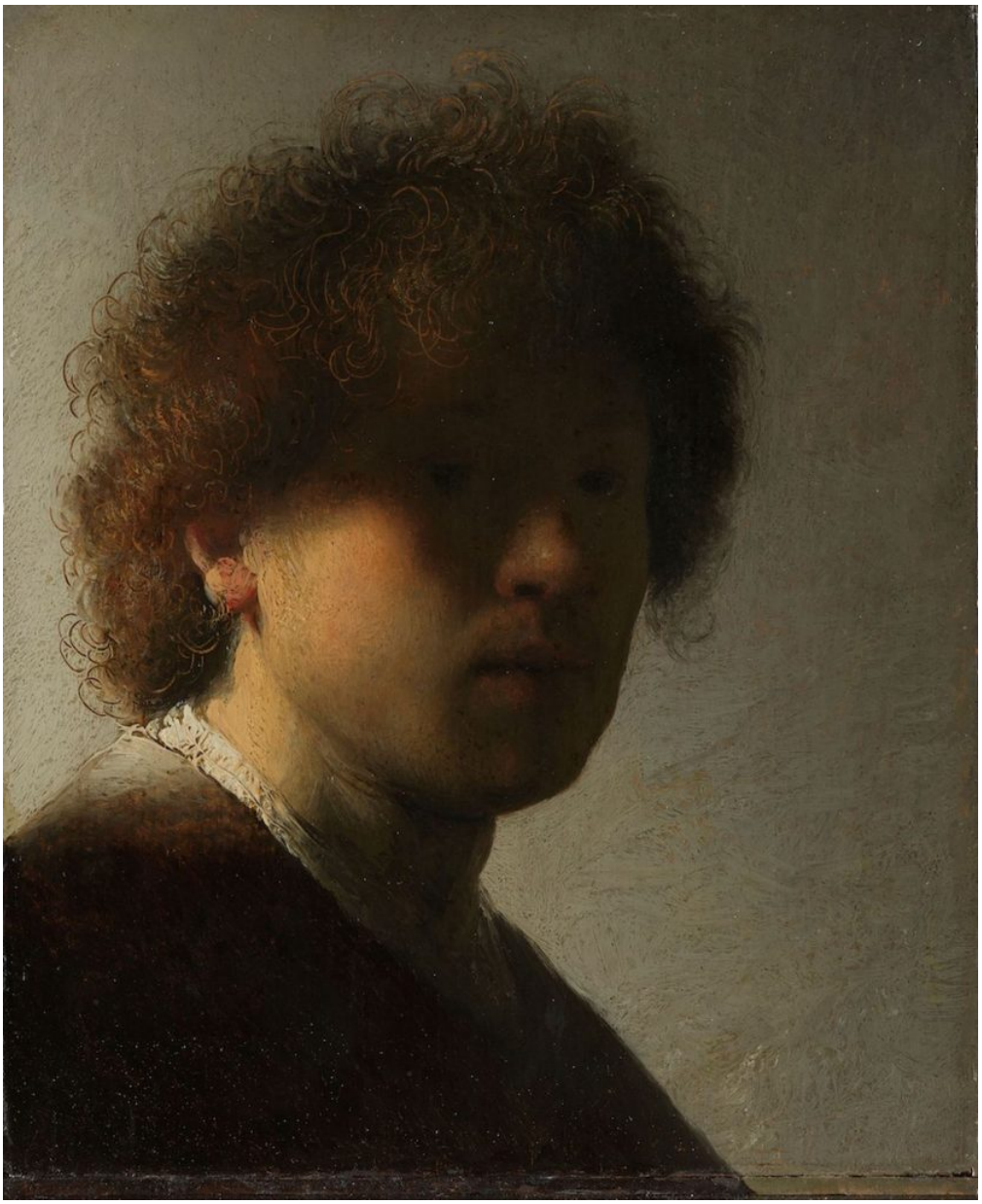
# ACO Population Health Best Practices: More Respect for Physicians and Patients

written by Theresa Hush | November 1, 2018



How important is it to agree on principles and best practices for population health? More important than most providers believe, and here's why: Population health can be a powerful engine for improving patient outcomes and cost performance in Value-Based Health Care.

Failure to create a standard of population health practices means that every ACO or health system scrambles independently to create initiatives, without the benefit of broader experience

and results. The outcome? ACOs make similar decisions or duplicate others' programs with meager results. They may also inadvertently consign population health to safer territory as administrative instead of strategic and innovative initiatives. Or they may adopt initiatives once used by health plans for medical management that had limited, if any, success. They may believe it's prudent to do so; but as financial risk models expand, that weak strategy will cost providers both money and patients.

## Many Providers Don't Understand What Population Health Can Actually Accomplish

Population health is more enigmatic than it should be, because few people agree on what it means. That's because the meaning of population health depends on who is advocating for it.

Ask any ten health care organizations or ACOs about their activities in population health, and you'll undoubtedly find that several programs are deployed for that purpose, but with very different goals. Further complicating matters, since technology is often used to support population health, some providers view the very concept of population health as synonymous with technology and analytics instead of health care improvement. Rarely are overall initiatives organized into a set of goals for population health.

Here is a sample of four initiatives that fall under population health, with distinct, far-reaching objectives:

> Patient outreach to fulfill gaps in care—vaccinations, screenings and diagnostic tests appropriate for their condition;
> Medicare Wellness Visits to ensure attribution of services to ACO primaries;
> Post-emergency room patient contact to establish a bond with a primary care physician;
> Post-admission outreach and services to avoid readmissions, usually specific to certain conditions.

Population health also covers disease management programs and outcomes-improvement initiatives that target patients for case management or other services.

The popularity of certain initiatives is not accidental—population health projects are often also designed to enhance revenue (additional patient visits) and to increase competitive edge (create attribution to ACO versus others). In fact, initiatives are often "sold" to create a "return on investment" in business terms—rather than to improve patient health.

## Population Health Is a Misnomer—Grouping Patients Should Lead to View of Individuals

The term "population health" is appealing because it sounds both simple and holistic. The simplicity, however, is pure fiction. There is no one population to act upon, but, rather, many diverse groups of patients with different needs.

The origins of population health are philosophical and economic: shift the role of providers from simply delivering services to taking responsibility for health of their patients. But here's the key: *there isn't one universal population of patients with similar needs.* Patients have very different attributes and circumstances, along with distinct clinical needs. So, too, must be the solutions to improve their health status.

In today's consolidated health care environment, where business concerns influence health care strategies, population health frequently becomes oversimplified. That is the appeal of large "fill the gaps in care" programs. All too frequently, these and other programs are focused less on patients in the population, and more on how to achieve double duty by raising quality scores while increasing patient volume and related revenues.

To effect a real improvement in patient health, however, providers must differentiate diverse patient subgroups and examine whether group action can facilitate individual patient responsiveness. Efforts to document barriers to care, understand clinical implications for different groups of patients, and create effective programs for improving health must be woven into a panoply of initiatives aimed at clearing pathways for individual patients to achieve better health.

## No Guidebook for Population Health? Start with Values to Achieve Trust and Loyalty

Without a guidebook, how can ACOs succeed with fewer resources? They can organize their efforts around two fundamental goals:

> Ensure that population health initiatives support physician-based care to improve patient health, making partners of their physicians; and
> Respect patients and their right to choose, while increasing the tools they have to do so, making partners of their patients.

## Population Health Must Work With—Not Against—Physician-Provided Care

The purpose of population health should be to balance and support physician-patient care. Some ACOs, disappointed with results, work against their physicians, creating sidebar communications with patients that are not interwoven with physician-patient interactions. Physicians can be unaware that patients were contacted because population health technology may be documented elsewhere in the EMR or via independent technology that the physician doesn't see in the patient visit template.

Patients will be the first to notice lack of coordinated messaging or incongruent recommendations, and that botched communication will abrade trust in both the physician and the organization. No matter how small or isolated it may appear, every population health initiative requires a tie-in to the patient's physician so that the physician can affirm the objectives, respond to questions and cement trust with patients.

This means that any communication to patients must come from physician offices or under physician names rather than central organizations; physicians must be educated about the process and buy into the goals of various population health initiatives. Case management services, if adopted, must be coordinated and not independent of physician care, and results transmitted for physician view in the EMR. Additionally, when third parties such as case managers or patient coordinators gather patient information, physicians should document that they have read and validated that information with patients.

In other words, population health cannot be solely an ACO or organizational effort. It is a team-building exercise with team results.

## Population Health Must Cultivate Patient Decision-Making, Not Compliance

Population health initiatives may cover a range of outcomes or performance improvement goals, selected strategically by the organization. But organizations should be wary of adopting programs with simple goals of increasing patient compliance or demanding that patients schedule visits. Patients, especially younger ones with a savvy consumer instincts, are quick to cast these as revenue initiatives rather than improvements in patient care. Providers should carefully reconsider how to render services in order to reduce cost and improve convenience for patients.

Population health should include efforts to improve patient health care literacy and alignment

of their goals for better health. These can include:

- Tools for communication and information-sharing between physician and patient;
- Access to telemedicine visits, email and other means of remote communication;
- Shared medical decision-making processes;
- Support networks for vulnerable patients, including activities to connect family and community safety-net systems into the patient's care;
- Resolution of financial issues, including transparency in pricing and bundled pricing for patient comparisons.

The common theme for population health initiatives must be to treat patients respectfully, reduce bureaucracy and increase dialogue on health issues as well as costs so that the patient can make informed choices.

It's inevitable that some patients will fall through the cracks. Event-based projects to follow up on patients with frequent ER use or recent admissions should be included in population health, but the context is important. These initiatives are more powerful if they are integrated into overarching initiatives to improve physician-patient connections and communication.

## Population Health Roadmap Should Be Flexible, Based on Tested Results

Concepts of patient responsibility and even patient outreach are relatively new in health care, and they are emerging at a time of high distrust and antagonism between consumers and health care institutions. All the more reason for providers to create a population health strategy based on these key elements:

- Develop a thorough understanding of the patient population derived from data and analytics—but with additional patient feedback on issues of access, trust, quality and cost;
- Collaborate with providers to construct models that build upon, rather than disrupt physician-patient care;
- Pilot and test results, and evaluate all initiatives regularly with a variety of tools—with input from both physicians and patients

As we proceed down the path toward Value-Based Health Care, it's time to abandon the simplistic ideas of population health, management of patients and their outcomes, and physician or patient compliance. The best future, built on a foundation of good data, will be defined by collaboration and partnerships.

*Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.*

Image: Self-portrait, Rembrandt van Rijn, c. 1628, courtesy of the Rijksmuseum.