The phrase population health management (PHM) has been spreading across the health and hospital sector with fervor. Hospital administrators are hearing the term at conventions and reading it in industry publications. There are many questions as to its meaning, its components, and why hospitals are increasingly looking to develop programming that supports a PHM strategy.

This white paper concentrates on the following:

- What does PHM mean?
- What are the key components?
- Why does PHM matter?

We have taken the tact of focusing on how a hospital, as the employer and operator of its own employee health plan, would begin to construct its own PHM strategy.

"The phrase population health management (PHM) has been spreading across the health and hospital sector with fervor."
**What does Population Health Management mean?**

Broadly speaking, the objective of population health management is to improve the health outcomes of the individuals who make up a larger group such as a community in a given geographic area. At the more granular level PHM strives to make the primary care physician (PCP) a leader of care delivery while giving the patient ways to assume responsibility for his own care. The underlying support systems (referral mechanisms, technology, alliances with other providers, etc.) have a greater chance of success if appropriate automation and mechanisms are in place to support both the PCP and the patient. PHM seeks to go beyond just “sick care.” PHM looks to address the needs of both high-cost claimants while also focusing on preventive care and managing chronic conditions.

A PHM strategy must be designed specific to each hospital or health system and the communities that they serve. There is not a blueprint or an off-the-shelf technology that prescribes or executes a PHM strategy. A hospital’s ultimate design of a PHM strategy will pivot on the unique attributes of its community (demographics, income levels, industry, etc.). It must also consider factors such as geography, hospital capabilities, physician networks, the hospital’s relationships with facilities and physician networks, potential for risk-sharing arrangements, and the ability to “productize” the model with simplicity for replication and application to other population sets (such as an area employer).

In today’s insurance environment, individuals are being asked to assume greater accountability of their own health care. But, the typical patient is not equipped to navigate the health care system to achieve the best economic and health outcomes. Therefore, the structure surrounding a patient is what matters. Guidance and oversight of care through the care continuum is what enables an individual to achieve better health and for that individual to cost less to keep healthy. The consistency and repeatable practices (from both the providers and the patient) is what will make the difference in improving the health of the entire population, patient by patient.

Hospitals are realizing that they must start with their own employee population so that the system built for their own employees can be replicated for area employers and the community at large. The health system/hospital must develop proof points within their own employee population in order to communicate its new system to others in the community.
Primary care physicians become critical in developing a care plan that is customized to the individual patient.

**PHM key components:**

- **Physician leadership:** Physicians are the central element of population management. Therefore, physician leadership is vital to this effort. By embracing the shift away from “doing more to earn more” physician partners lead the provider system to a system of reward for outcomes. Primary care physicians (PCP) need physician leadership to help them provide care that is consistent with the goals of population health management.

- **PCPs:** Primary care physicians become critical in developing a care plan that is customized to the individual patient. PHM depends on the PCP leading a team of mid-levels that together become the “home base” of primary care for a large panel of patients. Part of the objective of PHM is scaling for larger populations, which can only happen if the PCP is leveraged upwards by the primary care team.

- **Data analysis:** Population stratification for risk profiling is the building block for understanding current gaps in care. It is foundational. Ultimately, information that is refined to the patient level for individual health profiling is the vehicle for the PCP-led patient care plan. Because it is individualized, biometric analysis is a major step in that direction. Population stratification and biometric reporting is different than information pulled from an electronic medical record because it allows for a multi-year, longitudinal perspective for an entire population through the use of claims data.
Automation: Technology allows for information to be pushed to patients rather than relying on the patient to seek out the information. Two examples:

- Patient-specific awareness: Will health systems be able to implement a system that recognizes clinical protocols on a single patient and alert that patient of his need to address a chronic condition?

- Technology applications: Instead of telephonic outreach from the physician’s office to the patient, can messages not be sent via email, text, automated phone calls to keep the patient informed of health steps he should be taking? Technology allows for information to push to patients rather than relying on a patient to seek the information himself.

Referral mechanisms: Alliances with other providers who can assist in the care continuum is crucial, especially for hospitals that do not have tertiary and quaternary care capabilities. Business agreements between provider groups to facilitate the hand-off of a patient back to his PCP allows for the care loop to be completed.

Physician incentives: A PHM strategy is not predicated on uprooting a fee-for-service model. It does, however, introduce new payment structures for the PCP based on outcomes of the population. There must be a volume of dollars that is sufficient to get PCPs’ attention (both financial gain and loss to the PCP), recognition of leakage from the referral system, and “score keeping” for reporting transparency from one PCP to the next.

Benefit program coordination (including wellness): Most Americans follow the lead of their medical benefit program that is provided by their employer. The benefit design is the mechanism by which an employer can take advantage of a PHM strategy so that the employee has a financial incentive to participate in a more accountable system of care.

Replication ability: The main idea behind PHM is that it can be applied to the community at large. Therefore, simplicity of structure is imperative for area employers to take advantage of PHM’s strengths.
Addressing how each employee experiences the care delivery continuum—or lack of continuum—has a major impact on how much it will cost to provide quality care for that person over time.

Why does it matter?

It matters because our patients are expecting more from their care providers. Affordable care continues to gain attention at the national and state level. Affordability of care is paramount to individuals and employers who are struggling with rising health care costs. Most employers still fund about 80 percent of the costs that their plans incur, and those costs are a direct result of the factors in a given employee group health risk profile. Addressing how each employee experiences the care delivery continuum—or lack of continuum—has a major impact on how much it will cost to provide quality care for that person over time.

This paper intends to give the reader a view into the components required to develop a population health management strategy. Hospitals may consider this rubric to test the concept, build the system for their unique population, and then use what the hospital learns to expand the strategy to the overall community population.

Thank you for reading.

Bill Lindsay and Ed Pierce
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