



Science.
Applied to Life.™

3M Health Information Systems

Population health management:

A bridge between fee for
service and value-based care

Balancing multiple payment models

Although 85 percent of healthcare reimbursement is currently based on fee-for-service systems, the public eye (state payers, commercial payers and providers) is on accountable care, shared-risk payment, and provider-owned health plans. By 2020, it is expected that overall revenue at risk will be 50% or greater,¹ fueled by a trend toward value-based contracts that base at least some reimbursement on cost and quality targets.

What makes value-based payment such a hot topic is not just the growing level of reimbursement at risk, but the difficulty organizations face balancing multiple revenue models.

Easing the shift to value-based care

Government agencies, health plans and healthcare providers alike find it difficult to reconcile different, often conflicting, incentives and revenue management strategies. One way to bridge the disconnect is by applying principles of population health management. They align the metrics, incentives and interventions that guide decision-making for healthcare networks, clinicians and patients. A population health framework supports collaboration among payers, providers, and community partners—a critical component to developing a program that can be implemented at scale and sustained over time.



**50% of revenue
is estimated
to be at risk
by 2020.**



Rather than focus exclusively on individual diseases, population health management incorporates a whole-person perspective that considers overall health.

Building an infrastructure for population health management

Population health management is the practice of defining a group of individuals (the population), maintaining or improving their overall health, and managing their total cost of care, thereby minimizing the financial risk of the group. To do this, healthcare payers and providers need to help healthy members keep fit and help chronically ill members successfully manage their conditions, including individuals who may not be seeking care or visiting multiple care providers.

Population health management is a patient-focused approach to care as opposed to managing on a case-by-case or disease-by-disease basis. Yet it views clinical and financial risk across a group of people, employing metrics and interventions that boost patient experience (satisfaction), clinical outcomes and cost savings.

3M promotes a model of population health management following five principles.

The five principles of population health management

1 Identify and engage patients

It's necessary to understand both the patient's behavior and health status. Include individuals who haven't visited a primary care provider for over a year, those who see multiple specialists and super-utilizers.

2 Navigate patients through the system

Provide patients with timely access to care, comprehensive services (no gaps) and coordination among healthcare providers.

3 Help patients achieve their goals

Individuals can often describe why they struggle with improving their health. A systematic approach responds to patient-reported risks and engages individuals in managing their health more effectively.

4 Provide transparent measures of cost and quality

Organizations need information such as total illness burden, utilization across lines of service and total cost of care at both the population and individual member level.

5 Nurture sustainable care delivery models

New payment and care delivery models need to contain or reduce costs throughout the entire system, not shift costs from one setting to another. New models must also reward innovation and excellence.





How population health can prepare an organization for value-based payment

Population health management principles and capabilities can benefit any healthcare system, regardless of how much reimbursement is at risk. Even organizations that operate within a hybrid fee-for-service model can use population health management to identify high-cost and at-risk patients, understand the impact of adverse events, and implement prevention programs to minimize quality-based penalties. How does population health management help?

- **Providers learn to identify high-risk patients and prevent adverse events** as they understand the costs of delivering episodes of care as opposed to single encounters. They develop systems to engage patients.
- **Payers and providers gain better visibility into effective care delivery.** They align incentives, harmonize performance metrics and prioritize resources (e.g., care management) to respond to the distinct health needs of different patient populations.
- **Consumers understand and make better healthcare choices.** By having access to relevant cost, quality and health information, especially through meaningful patient-provider communication, consumers become more confident and satisfied with their health care.
- **The healthcare system shifts from disease management to patient-centric care.** By focusing interventions around the patient as a whole in addition to specific diseases, payers and providers create the most impact on improved patient health, total cost of care and financial outcomes.
- **Healthcare networks focus more on community-based health.** Population health management provides a framework for organizations to redefine their business models so that timely care (including preventive care and health education) is provided in the most appropriate setting.



Putting population health management into action

Population health management, and the new payment models needed to support it, are not new topics. The concepts have been discussed since the late 90s. However, the technology to support these payment changes has lagged behind.

Managing a mix of value-based payment models, which is the reality for most organizations, is too complex and costly without the appropriate information technology (IT). Value-based payment is only now practical because technology has advanced enough to help payers and providers know what care is needed, when and where it should be provided, what it will cost, and who should pay for it.

To effectively use data to manage the cost and delivery of care, organizations must develop new capabilities within their IT infrastructure and care management workflow. These capabilities also need to expand strategically and proportionately as organizations pursue more aggressive risk-based payment.

The IT capabilities needed for population health management



- **Integrate data**

Acquire, aggregate and standardize clinical, claims, socio-demographic, and care management data across the care continuum.

- **Define and stratify**

Define the target population; normalize all relevant patient data; and analyze and stratify target populations based on clinical, financial and demographic risks.

- **Identify care gaps**

Identify and address any gaps in care.

- **Engage patients**

Engage patients in actively managing their own health care.

- **Manage care**

Coordinate care for healthy and ill patients across the continuum, especially transitions of care. Refer patients to appropriate providers.

- **Measure outcomes**

Evaluate clinical outcomes, cost of care and patient satisfaction with care management programs. Identify shortfalls and areas for improvement.

- **Analyze data**

Apply advanced algorithms and predictive methods to determine probable outcomes (e.g., predict patients at risk for readmission, determine persistent high-cost).

- **Report to stakeholders**

Generate, format and export data. Facilitate delivery or exchange of data to external stakeholders.

- **Communicate with physicians and patients**

Provide convenient access to health information, with or without an EHR, including relevant alerts within clinicians' natural workflow (e.g., user portals with web, desktop or mobile access).

- **Standardize business processes**

Integrate with other programs and systems to provide a simple, seamless workflow.



The Colorado Accountable Care Collaborative used population health strategies and achieved an average **\$100 million** in gross savings and **\$31 million** in net savings.

Case study: Better care, lower costs for Medicaid

Colorado's Medicaid reform program, the Accountable Care Collaborative (ACC), has a population health mission—improve member health, improve member and provider experience, and contain costs. To achieve these goals the program uses a mixed payment model: fee-for-service reimbursement with value-based rewards. This payment strategy helps the healthcare network shift from delivering a high volume of services to achieving cost-effective outcomes for members. The ACC uses regional care collaborative organizations (RCCOs) to provide a network of primary care medical providers (PCMPs). Every new ACC member is connected with a PCMP that ensures they receive coordinated care in a medical home environment.

The RCCOs and PCMPs receive access to health IT that helps them see patterns in how members use healthcare services, such as which services are used most frequently and which are needed most in a specific region. Data helps the program administrators spot areas with higher-than-average utilization or populations with complex medical needs. It also identifies members with chronic health conditions who need care coordination and health coaching.

The RCCOs and PCMPs can also track key metrics such as emergency room visits, hospital readmissions, high-cost imaging, well-child visits and post-partum care. This ability helps them manage the value-based payment component of the ACC, which grants them incentive payments when they meet or exceed targets in these areas.

In 2014, the ACC achieved gross savings in medical costs of about \$100 million. After administrative expenses, the net savings totaled about \$31 million.²

A foundation for population health management

3M supports payers, government agencies and providers in **building their population health management capabilities**. Our tools and services can help you find answers to such questions as:

- *What is an individual's level of risk?*
- *Who is at risk of needing high-cost care?*
- *How should we measure health goals?*
- *What is fair payment?*
- *How do we incentivize providers and consumers to manage health differently?*

Whether you're a payer or provider currently in a fee-for-service model with minimal risk-based contracts or in a value-based model where financial risk is shared, **3M has the capabilities to guide you along the journey.**



3M tools for population health management

3M™ APCD Solution Suite provides data warehousing, analytic tools and strategic consulting for organizations that want to create a multi-payer database.

3M™ Healthcare Transformation Suite helps healthcare payers implement and manage value-based care and population health programs collaboratively with providers. The suite is a collection of consulting services and analytics tools, such as performance dashboards, predictive models, care management reports, analytics platforms and learning resources, designed to move payers and providers from volume- to value-based models of care.

3M™ 360 Encompass™ – Health Analytics Suite offers advanced analytics tools to help providers manage the health of populations, measure physician performance, determine total cost of care and gain insights for a more successful entry into population health management. Each module of the suite illuminates a hospital's performance in a variety of key measures, helping an organization make the best possible strategic decisions for both today and tomorrow.

References

¹Becker's Hospital Review. *20 major health systems, payers pledge to convert 75% of business to value-based arrangements by 2020*. Available as of 03/16 at <http://ow.ly/Zbkv>.

²Colorado Department of Health Care Policy and Financing. Response to the Joint Budget Committee's Request for Information regarding the Accountable Care Collaborative. Fiscal Year 2013-2014. Available as of December 2015 at <http://ow.ly/MfRnJ>

For more information on how 3M software and services can assist your organization, contact your 3M sales representative, call us toll-free at **800-367-2447**, or visit us online at **www.3Mhis.com**.



Health Information Systems
575 West Murray Boulevard
Salt Lake City, UT 84123 U.S.A.
800 367 2447

www.3Mhis.com

3M is both a trademark and a service mark of
3M Company.

Please recycle. Printed in U.S.A.
© 3M 2016. All rights reserved.
Published 03/16
70-2011-6604-1