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'Simply having data is not enough'

By Betsy Hampton, R.N. | June 5, 2017

Some people mistakenly think that population health means just instituting care management or having skilled nurses visit patients. In fact, it means looking at the full spectrum of care in multiple ways — by deploying analytics, allowing plans to delegate referral management to provider groups, and finding and filling care gaps.

And technology is the key to making that work. At Reliant Medical Group, which has 500 providers caring for more than 320,000 patients at 25 locations in Massachusetts, our secret sauce is leveraging the capabilities of electronic medical records to support our population health efforts.

Analytics and EMR: Just the facts

At Reliant, we issue alerts for evidence-based best practices. We remind our providers about quality outcomes. We create disease registries, so we are aware on January 1 which patients will need their A1c test, colonoscopy, or mammogram in the coming year. We embed clinical pharmacists in our medical practices to ensure that depressed patients are getting their medications.

One of our biggest recent improvements was creating our own analytics team. When I arrived at Reliant, we depended on our finance team to provide medical cost analytics. Because the finance team supports the entire organization, we felt we didn't have timely enough access to the analytics we depended on.

So we started our own analytics team and built dashboards for use, right down to the provider level. While we continue to collaborate with our finance department, having our own analytics capabilities has enabled the office of population health to have ready access to the data our providers need to manage care.

Delegating to lower costs and boost quality

Another critical component for us was delegation — allowing plans to delegate to a provider group the ability to manage the plan's benefits for its patients. Our nurses determine what the benefits are, including where our patients can go for specialty care, skilled nursing, and home health. By managing that full circle of care, we deliver a lower-cost, higher-quality program.

I came from a health plan background, so I knew managing expenses required managing benefits and referring patients to our own specialists and preferred organizations, instead of to providers outside our control or stewardship. From my perspective, being delegated was a must. By becoming delegated and taking global risk, we could get higher PMPM — payments per member per month — and we invested those dollars in care management.

Zero in on high-risk patients

Once you have analytics and delegation, my motto is: Identify high-risk patients, and manage their care aggressively. Guide those patients through the continuum. Plan what you need to make sure there are no gaps in care.

A common misconception is that if doctors have the right data, they will do the right thing. But physicians are very busy, and simply having data is not enough; we must provide them with as much support as possible. That comes in the form of staff who can work with patients outside of the exam room, including case managers, social workers, behavioral health managers, nurse practitioners, UM nurses, and hospitalists.

In urgent care, we started our own infusion therapy to move a large percentage of our biologics out of hospitals to bring down costs. In the process, we created a more convenient service for our patients.

When high-risk patients go to a hospital, our utilization nurses review their cases and send them to the proper post-acute care facility. The transition care coordinator calls 24 hours later to make sure everything is in place. Other care managers are referred to follow the cases.

At the same time, our EHR system has a header that identifies each complex patient. It flags those who call in to a provider, so the nurse can make sure he or she is booked for an appointment. And care managers can see if a patient is overdue for an exam such as A1c. The information is all in one place, and every member of the team can see it.

Next steps

Our journey is far from over. Our next area of focus is to develop a stronger community network of services and to connect with them through our EHR. We still need to improve our analytics. We have not gotten to “big data” yet — identifying social determinants, predicting rising risk, and so forth.

We know where high risk is, but we are not yet predicting rising risk. We also have recently identified a big gap in our end-of-life, hospice, and palliative care. We have a long way to go to better identify those patients and get them into the appropriate level of care as early as possible.

We also still have progress to make with our Medicaid population. We do better than most in terms of managing care efficiently, but we haven’t made quantum leaps in performance. We believe this is becoming more of a community effort than just a medical group effort. We need a better network of behavioral health and substance abuse care, particularly with the opioid problem.

In any journey to population health, people have to understand that there is no easy solution. My advice is to begin with filling the gaps in your care continuum. Use analytics to identify high-risk patients. Get delegated if you are taking on global risk, so you can manage your referral circle and have more authority in your hospitals. And support your providers by having the infrastructure in place so they know the right thing to do next.

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