A Roadmap for Population Health: Best Practices for Achieving Operational Alignment

Larry Yuhasz

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Reform under the Patient Protection and Affordable Care Act (PPACA) demands a contractual and financial shift from volume to value, and an operational shift from fee-for-service (FFS) to an “at-risk” payment structure. Within these shifts, there are many dynamics at play. Traditionally, FFS is focused on efficiency, but to move toward at-risk, the focus shifts to effectiveness, while still maintaining efficiency.

As providers take on more risk and combine clinical and administrative data, they find themselves better positioned to embrace and drive population health.

The Operational Alignment Challenge
Making the shift is really a challenge of operational alignment. When we talk about a roadmap for population health, it’s about aligning components you already have so they can operate in different ways, for different purposes. It’s also about augmenting a certain component to make it function better in concert with other components.

In this paper, we’ll discuss:
- The Payment Reform Challenge: Balancing Efficiency and Effectiveness
- Achieving Alignment: Evolution to a “Learning System”
- Putting It All Together: Key Considerations
- Outcome of Alignment: A Learning System
- Conclusion: Where Do You Want to Be in 5-7 Years?

The Payment Reform Challenge: Balancing Efficiency and Effectiveness
Today, a small percentage of providers, such as Kaiser Permanente and Geisinger Health System, operate in a fully capitated environment. Meanwhile, several others are already participating in the Medicare Shared Savings Program (MSSP) — with a second round taking place in 2014; in pioneer accountable care organizations (ACOs) — many of which have already come and gone; in commercial ACOS that continue to expand; or they may be involved in some sort of advanced payment structure.
No matter what the operational environment, it’s important to review some recent statistics. According to an August 2012 article in *Kaiser Health News* titled, “Medicare to Penalize 2,217 Hospitals for Excess Readmissions,” nearly one out of every five Medicare patients returned to the hospital within a month of discharge, costing the government an extra $17.5 billion. In 2013, due to the implementation of the PPACA, those types of issues will cost you in penalties. A 2013 *Kaiser Health News* article titled, “Armed With Bigger Fines, Medicare to Punish 2,225 Hospitals for Excess Readmissions,” stated that almost $230 million in penalties will be taken from 2,225 hospitals for re-admits on heart attack, heart disease, or pneumonia patients this year. That’s why it’s so important to optimize your operational alignment so your facility can function effectively under new payment reform scenarios.

Ten years from now, it is very likely that most providers will function in a hybrid environment that has a mix of FFS and varying at-risk revenue streams. This creates a great deal of complexity. Even today, hospital systems are charged with the task of aligning their operations to be successful under each revenue scenario, so they will also function well in a hybrid of both.

**100 Top Hospitals Achieve Quality, Efficiency, Patient Satisfaction, and Leadership Effectiveness**

To determine which operational alignment practices make the most sense, it pays to study and emulate organizations that have been able to achieve a balanced overall performance that includes quality of care and patient satisfaction, as well as efficiency and financial stability.

The annual Truven Health 100 Top Hospitals® study is independent, quantitative research that identifies the nation’s best hospitals. At the heart of the study is the 100 Top Hospitals National Balanced Scorecard, which is comprised of equally weighted measures of key organizational functions and outcomes — financial performance, operational efficiency, patient safety, quality inpatient and post-discharge care, and patient perception of care. Leading performers demonstrate the capacity to achieve outstanding performance across the study metrics and provide high value to their communities.

The annual 100 Top Hospitals study measures the impact of leadership on the maturation of the performance improvement culture, as well as the degree of alignment across the organization over 5 years and the resulting effect on the hospital’s or health system’s rank nationally. Because of this, Truven Health was selected by the National Institute of Standards and Technology to conduct a study to validate that hospitals using the Baldrige criteria for performance excellence were performing at higher levels than other hospitals (“Comparison of Baldrige Award Applicants and Recipients With Peer Hospitals on a National Balanced Scorecard,” October 2011).

The study found that Baldrige hospitals showed a long-term rate of improvement that was six times faster than their peers over a 3-year period. Baldrige winners were also two times more likely to achieve 100 Top Hospitals performance levels than peers at that time.
Attributes of Top-Performing Hospitals

After comparative research on the nation’s top-performing hospitals, Truven Health has been able to identify many of the attributes that contribute to their success — most notably, the ability to build and maintain a mature culture of performance improvement, as well as a laser focus on the alignment of organizational performance. Research has also shown that 100 Top Hospital award winners are quicker to adapt to systematic measurement of advanced protocols and evidence-based medicine, and have been earlier adopters of electronic medical records (EMRs) than their peers (2012 HIMSS Analytics Report: “Quality and Safety Linked to Advanced Information Technology Enabled Processes,” April 2012).

Other key factors include:

- Strong evidence of collaboration and of leadership’s ability to break down silos, either departmentally, between systems, or among data sources within the hospital system.
- Superior communication of common goals that cut across care settings, and common data that can be leveraged for decision support at the point of care.
- Diligent commitment to process, including benchmarking where to begin, measuring performance, analyzing the results, and striving for ongoing performance improvement. Process commitment can be challenging in the intensely complex hospital environment, but it can also be incredibly rewarding and provide a competitive advantage if you stay the course.
- The ability to simultaneously focus on both cost and quality — not one, then the other.
- Becoming a data-driven “Learning System,” where it’s not good enough to collaborate, get data, and establish a process commitment; you have to have the courage to learn from those things and change.

Achieving Alignment: Evolution to a “Learning System”

Several capabilities need to harmonize to become a successful population health management entity. This convergence of capabilities evolves into what we’ve coined a “Learning System.” This is a system that continually monitors performance and feedback to make intervention selection, quality outcomes, and cost-savings more effective. In short, it’s a system always learning from its successes, as well as its mistakes.

To become a Learning System, you must align four key operational domains:

1. Health information technology (HIT)
2. Analytics
3. Workflow
4. Care team engagement

Strategic Direction for Operational Alignment

To begin converging these key domains, it is important to develop a strategic direction and optimize each domain individually.

1. HIT: First, connect all the patient data into a single, unified patient record to ensure improved speed and accessibility across the care team. Especially if you’re transitioning to at-risk in the early stages — whether it be commercial, ACO, MSSP, or patient-centered medical home — it’s critical to assess and optimize workflow. Also be diligent about improving adoption of your technology and increasing usability, because the whole effort is pointless if no one is using it or it’s too hard to access.
Can You Achieve a Single Patient Record: Current and Emerging Data Types

2. **Analytics**: There are several analytic requirements for effective population health management. You must transform and stratify the data to drive proficient decision-making; you also need to identify and prevent risk and alert both the physicians and the patients. Additionally, you have to measure quality and cost performance, determine your intervention efficacy, and measure at-risk performance.

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Do You Have an Actionable Analytic Agenda?
Defining Populations of Interest, Care Settings, and Requirements

<table>
<thead>
<tr>
<th>Patient Populations</th>
<th>E.R.</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Owned</th>
<th>Affiliates</th>
<th>External</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>Who refers our patients?</td>
</tr>
<tr>
<td>Panels</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>What is the mix of patients by physician? How frequently and why do we encounter them?</td>
</tr>
<tr>
<td>PCMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>What is our primary care performance across conditions and levels of care?</td>
</tr>
<tr>
<td>Registries</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>Are we collecting the right data for specific chronic condition requirements?</td>
</tr>
<tr>
<td>Discharges</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>Who was discharged and why? What were the care expectations and did they receive them? Did they comply?</td>
</tr>
<tr>
<td>Re-admits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Where do re-admits occur? Which patients/physicians? Cost implications?</td>
</tr>
<tr>
<td>At-Risk, Clinical</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Which patients have quality/safety gaps? Emerging risks?</td>
</tr>
<tr>
<td>At-Risk, Financial</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>Where do we have strong and weak performance against at-risk contracts?</td>
</tr>
</tbody>
</table>

3. **Workflow**: The more you can automate care guidelines and enable your care team, the better. Support patient engagement in post-discharge interventions that are tied specifically and concretely to care management guidelines. Measure them so the learning cycle can occur and interventions can be reviewed and enhanced over time. Capture compliance measure, as well, to determine whether caregivers disseminated the post-discharge care guidelines and whether patients are in fact
complying with them. Lastly, begin to align performance with at-risk contracts. In most environments, the at-risk revenue is very small compared to FFS, so the operational investment to connect them hasn’t happened. But as organizations transition to an at-risk payment structure and it becomes more the norm, it will be increasingly necessary to invest in your workflow.

Three Key Workflow Requirements

Systematically preventing identified risks requires deep analytical skills, commitment to reporting life-threatening/changing errors across all departments and services, and courage to fix the errors.

<table>
<thead>
<tr>
<th>Care Redesign</th>
<th>Best Practice Review</th>
<th>Work Redesign Methods</th>
<th>Change Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management</td>
<td>Stratification</td>
<td>Triage</td>
<td>Intervention</td>
</tr>
<tr>
<td>Preventable Events</td>
<td>Identification</td>
<td>Surveillance</td>
<td>Feedback</td>
</tr>
</tbody>
</table>

4. Care team engagement: Work to configure new HIT tools and help your team adopt them. Then triage and select interventions to meet your requirements, improve the team’s care coordination, and assess patient compliance. Once you have the data, evaluate the outcomes and determine your intervention efficacy to help you determine a strategy for ongoing improvement.

Important Physician Engagement Interfaces

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<table>
<thead>
<tr>
<th>External Performance</th>
<th>Contractible Commitments</th>
<th>Payer Measures</th>
<th>Compliance Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Performance</td>
<td>Clinical Outcomes Costs</td>
<td>Compared to Peers Internally</td>
<td></td>
</tr>
<tr>
<td>My Interventions</td>
<td>Patient Worklist</td>
<td>Action Steps, Alerts</td>
<td>Lab, Rx Orders</td>
</tr>
</tbody>
</table>

External Views
Benchmarks
Local Level
Performance Review
Personal Work Flow
Configuration
Putting It All Together: Key Considerations

Think of these key considerations like concentric circles, each layer relying on and building upon the previous ones. At the center is the single patient record. The next layer is population health analytics and the outer layer is care management applications.

Every hospital system is taking a different path on the road to population health. Although there are many different avenues to achieving alignment, the key is that you have to think about your system as a whole.

Outcome of Alignment: A Learning System

Successful operational alignment ideally results in your organization becoming an active Learning System. A Learning System has the ability to see and collect data in real time, while a patient is in the hospital. It can focus on that patient’s particular requirements, forecast what is coming, and apply knowledge for improvement based on patterns. The system can also predict and prevent problem areas, target improvement efforts for its care team, implement quality improvement (QI) tactics, and collect process and outcomes data.

Additionally, a Learning System needs to take a retrospective perspective and look at the last week, month, quarter, and maybe more. It needs to aggregate data across the population, look for trends in historical performance, and identify the patterns and problem areas. Then, the system must target QI for care managers, drive those QI priorities and strategies, and lastly, determine the efficacy of those interventions.

Five Characteristics of an Active Learning System

How do you know if you’ve achieved Learning System status? Here’s a list of five characteristic abilities to look for:

1. First, you’ve been able to integrate the data. Whether through an enterprise-wide EMR or some other interoperability platform, you have a single patient record.
2. Next, you have the capacity to transform and stratify that data to drive your population health analytics.
3. You have a mechanism to create predictive risk scores, either through external vendors or a homegrown system, so you can predict and alert.
4. You can successfully triage and select interventions to inform your care management applications.
5. And very importantly, is the ability to track process outcome measures and be sure those processes actually occur.

Once your system can demonstrate each of these five characteristic abilities and collect the knowledge from each of these experiences, the learning cycle is complete. Then, you can begin to perform intervention studies from all the data you have gathered and discover ways to increase your efficiency and effectiveness. Putting the data into action — having the courage to use it to change the way your facility performs — is what makes an organization a successful Learning System.

**Conclusion: Where Are You Now?**
Everyone wants to assume their facility is well on its way to successfully transitioning from FFS to at-risk. But are you still working to achieve balance between efficiency and effectiveness? Do you have all the components of HIT, analytics, workflow, and care team engagement? And if so, are you in the process of connecting them so you have an ongoing process discipline?

**Baseline Your Current Readiness: A Checklist**
To get a sense of your current situation and discover where your organization is on the roadmap to population health, use this checklist to analyze whether you have the components under each heading. Knowing where your gaps are will help you plan your strategic direction, achieve operational alignment, and target outcomes.
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