Guide

Optimizing Health Plans with Population Health Management Strategies

- Learn how to improve member health, costs, and satisfaction via population management
- Discover how to navigate common pain points using population health management programs
- Get tips on how to implement a population management program at your organization

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Introduction to Population Health Management

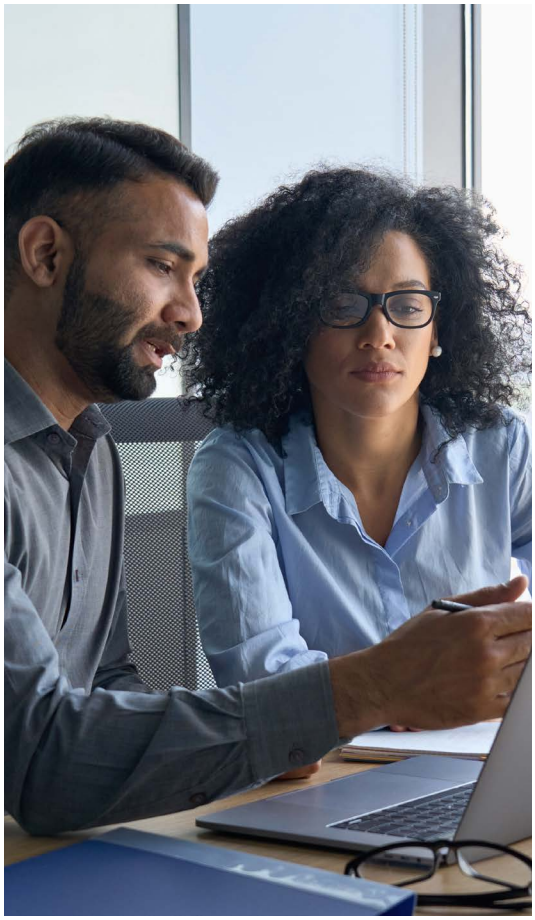
Population Health Management (PHM) is a holistic approach to developing a tailored care model designed to improve the health and well-being of defined populations and subpopulations. With targeted programming, it's possible to manage member risk and provide integrated, coordinated care that enhances member engagement, health outcomes, and financial incentives and rewards. Through an effective population health management program focused on population health strategy, cost of care, and member experience, payers can lower overall healthcare spending and improve the health and well-being of the communities they serve.

Learn how PHM can improve healthcare outcomes and ensure that high-risk members receive the right care, at the right time, in the right place.

Contents

Defining Population Health Management

Population management leverages data analytics to segment members into cohorts with similar characteristics and target those cohorts with personalized services and care for better overall population health.



For a PHM program to be successful, it must bring clinical, operational, and financial data together from across the enterprise and provide actionable insights to help improve efficiency and patient care. Delivering on the vision of PHM requires a robust care management and risk stratification infrastructure, a cohesive delivery system, and a well-managed partnership network providing real-time insights to clinicians and administrators, helping them identify and address care gaps within the member population. Having an enhanced care management program is essential for better outcomes and cost savings, especially in populations with high utilization or chronic diseases.

Care management is a critical component of PHM. While the objectives of care management can vary from organization to organization, they tend to revolve around engaging impactable members, improving self-management, improving medication management, facilitating appropriate access, and reducing the overall cost of care.

Keys to Effective Population Health Management Programs

The critical components of effective population health management programs vary due to the complexities of our healthcare system.

In the United States, the per capita cost of healthcare is higher than in any other developed nation, according to a study by the Johns Hopkins Bloomberg School of Public Health. As our population ages—the number of Americans aged 65 and older is expected to double from 52 million in 2018 to 95 million by 2060—the need for reform is critical. Health plans and their partnering providers are increasingly acknowledging the shift to value-based care, and they are starting to turn their attention to developing the strategies and programs that will help them make the switch with the least amount of financial and operational discomfort.

The entire healthcare system agrees that a data-driven approach to proactive, preventative PHM is likely to produce more positive long-term outcomes for members. Identifying and engaging impactable members and helping them live healthier lives is the focus. Incentivizing a healthier population and partnering with the providers that care for them is an important goal.

A variety of services can improve PHM implementation.

- Identifying, stratifying, and supporting the management of complex and high-risk populations
- Moving population health management program performance to industry best practices
- Evaluating, developing, and redesigning Transitions of Care (TOC) programs
- Implementing plans for readmission avoidance and management
- Developing processes to ensure optimal place of care
- Advising on special needs and dual-eligible member programs
- Guiding enhanced Medicaid and government program care management strategies
- Offering guidance on clinical platform design, implementation, optimization, and operations
- Delivering population health analytics to identify and highlight new opportunities
- Supporting compliant, high-quality strategies for coordination of care in all lines of business

Common Population Health Management Strategies

Population health management is intended to help each member live a healthier life while avoiding crisis events, reducing preventable hospitalizations, and improving overall quality of life. Preventative measures can help PHM strategies achieve these goals.

PHM begins with gathering key demographic and clinical data. Important data for risk stratification may include the number and type of chronic diseases, history of high utilization or frequent hospitalizations, current medication and medication compliance, mental health or substance abuse diagnoses, advanced age, and other demographic or social data that provide insights into health equity.

Members with higher risk scores are targeted for additional support, including more frequent follow-ups, social and community support, enhanced care coordination services, enrollment in care or disease management programs, medication adherence interventions, or enrollment in an educational or patient support program.

Members with lower risk scores receive other focused interventions, such as automated screening reminders, options to communicate with providers online for minor health concerns instead of scheduling appointments, or small incentives to keep up healthy lifestyle habits.

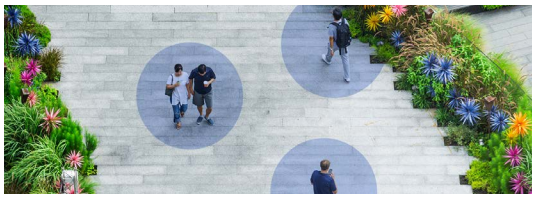
The PHM strategy is a cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification and standardized assessment processes. Each managed care plan would be required to include, at a minimum, a description of how it will approach a member-centric plan of care using a person-centered approach.

The ultimate goal of a PHM program is to establish a cohesive, statewide approach to population health management that ensures all members have access to a comprehensive program that leads to improved outcomes, health equity, and longer, healthier, and happier lives.

Implementing a Population Health Management Program

A strategic roadmap that starts with reasonable, bite-size projects capable of producing quick results is an essential component of any population health plan.

The first phase of implementing an effective PHM plan revolves around the ability to analyze member data, stratify the risk, and identify the patient population for engagement and impact based on predictive models.



That work will provide the foundation to help organizations understand their risk, allocate limited resources, build the needed capabilities, develop appropriate clinical and support programs, and engage members in outreach, screenings, and education.

Once an organization understands the people, power, and tech tools available, it can decide how to use them, how to augment them, and how to achieve its ultimate objectives as it strategizes the future goals of the PHM program.

Be sure to ask the right questions during this part of the process.

- Do we clearly see the socioeconomic issues facing our members? What is the average health literacy level? How will we communicate with them? Do the majority have access to the internet at home, or should we investigate a texting-based platform?
- Do we understand our geographical region and the health resources available to members? Can we reach out to the public health department, school districts, and community-based organizations to better understand the challenges of our service area?
- Have we thoroughly assessed our baseline data integrity and analytics competencies? Do we understand how our data accuracy, quality, completeness, and timeliness will affect our population health management insights?
- Do we have skilled staff on board to help meet these data challenges? Are we interested in working with a consultancy? Should we consider outsourcing any of our technology or business processes?
- Is there a local health information exchange organization that provides access to population health insights? Is there still a regional extension center nearby that can advise on technology adoption and planning?
- What is the first project we will tackle? What is its time frame, participation requirements, and expected results? How will we report on its outcomes, and what will we do with that information?

Clearlink & Population Health Management

Population health management programs can come with plenty of challenges, including a lack of data interoperability, insufficient talent and experience, financial constraints, and low levels of data integrity. But Clearlink can help your organization overcome potential obstacles and adopt successful PHM.

With our extensive clinical program expertise spanning risk stratification, population health analytics, case management programs, and platform selection, design, optimization, and more. Clearlink has the data, expertise, analytical skills, and support staff to help you develop a unique PHM strategy to fit your needs.

Get in touch with Clearlink today.

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About Clearlink Partners

Clearlink Partners is an industry-leading managed care consultancy specializing in end-to-end clinical and operational management services and market expansion initiatives for Managed Medicaid, Medicare Advantage, Special Needs Plans, complex care populations, and risk-adjusted entities.

We support organizations as they navigate a dynamic healthcare ecosystem by helping them manage risk, optimize healthcare spend, improve member experience, accelerate quality outcomes, and promote health equity.

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