Population Health: The Case Manager's New Frontier

Population health is a hot topic in healthcare right now. The term can be defined as the health outcomes of a defined group of individuals, as a result of both medical interventions and a wide array of other factors that influence health. For example, it's a well known fact that groups of people with higher education levels and greater socioeconomic status have better health than those living in poverty, even in countries with universal access to care. The field of population health provides the conceptual framework for thinking about why these disparities arise and why some populations are healthier than others.

The term "population health management" refers to purposeful actions taken to improve health outcomes in a defined group. It's a strategic process, because it relies not only on providing evidence-based medical care, but on understanding and influencing factors like the cultural, economic, and physical environment; individual health practices such as diet, personal hygiene, and exercise; health literacy and coping skills; and access to medical and community services. Ultimately, population health management (PHM) practices will be used to shape the social and health policies that drive these factors.

Within PHM, populations can be defined in many different ways. They may be geographically defined groups, like the citizens of a region, county, or state. They can also be ethnic groups, employees of a corporation, members of a health insurance plan, or the asthma patients at a pediatrics practice. Regardless of how a population is defined, population health management can be a powerful opportunity for providers, payers, public health agencies, and community organizations to collaborate, in order to improve health outcomes in the communities they serve. Case managers are well poised to lead this effort by "connecting the dots" and coordinating both medical and non-medical needs.

Improving outcomes

Our current healthcare system was designed to respond to the acute needs of individual patients. It has typically focused on episodic care rather than continuous care – so even someone with a chronic condition like diabetes might not see a doctor until a complication sends him to the emergency department. This is starting to change: Under the Affordable Care Act (ACA) and certain Medicare payment reforms, healthcare is beginning to shift to a system that anticipates the needs of entire patient populations and shapes patterns of care for those populations.

For example, consider the population of post-operative inpatients requiring a urinary catheter. At one time, hospitals viewed a catheter-associated urinary tract infection (CAUTI) as an acute condition whenever it arose (as it inevitably did) and were paid more money for treating it, even as the individual patient bore the risk of potential complications, like sepsis. Today, Medicare will no longer reimburse for the care of certain preventable adverse events, including CAUTI. As a result, hospitals now view this specialized patient population differently, anticipating the likelihood of CAUTI and creating care plans for catheterized patients that minimize the risk of infection. Because

PHM-style strategizing now drives infection control policies at most hospitals, the entire population of catheterized inpatients – nationwide – has better health outcomes. And this is the essence of PHM – identifying and stratifying populations that can benefit from quality initiatives that are customized to the needs of that specific group.

Expanding access and outreach

The primary goal of the ACA was to improve the population health of the entire country, across state lines and socioeconomic strata, by improving access to the healthcare delivery system. It aimed to do this through Medicaid expansion, state and federal insurance exchanges, and the requirement that payers provide access to specific types of preventive services (like colonoscopy) without shifting any costs to the patient through deductibles or co-pays.

The ACA also promotes integrated care delivery systems, such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs), which offer physicians financial incentives to improve the population health of the group of patients it serves, rather than solely providing episodic care. Some of these newer, more patient-centric models, as well as large primary care practices, are already relying on case managers to coordinate services, monitor adherence to a treatment plan, and manage high-risk patients in order to prevent acute episodes. As PHM strategies and care management interventions become increasingly more sophisticated, it's important for case managers to understand this changing landscape.

Under the PHM mindset, providers and payers will not only coordinate the medical aspects of care, but address a broader range of factors that influence the health of various populations. These are known as the social determinants of health, and they include all the conditions that affect access to food, transportation, housing, employment opportunities, and freedom from discrimination and chronic stress. In this new healthcare era, clinicians and case managers must become aware of how these factors affect their patients' health.

As a very simple example, think of a patient with a chronic condition who misses medical appointments because she can't walk a mile to the bus stop, or who skips medication entirely during the last week of each month while waiting for the next Social Security check to arrive. Circumstances like these can lead to medical emergencies -- yet a skilled case manager will know how to leverage community resources to overcome such barriers. PHM is a flexible and comprehensive approach to care, encompassing risk-management and outreach strategies to provide patients with a spectrum of services aimed at correcting behavioral, economic, and environmental deficiencies.

Technology is key

Providers and case managers will have to rely heavily on technology to support population health management initiatives. Remote monitoring, telemedicine, smart phones, and wireless communications can help to optimize PHM strategies, care management plans, and outcomes. Data analytics programs will also be crucial. Case managers working with high-risk populations will need to use electronic registries to

track and evaluate the outcomes of specific interventions that have been applied to similar populations, in order to formulate their own strategies. They will also need systems that can track and report on both clinical and financial outcomes, create customized care plans, conduct risk assessments, and generate automated workflows with alerts to make sure benchmarks are being met and patients are not slipping through the cracks. Technology will provide the data needed to support the clinical process changes that result from PHM strategies.

As population health management shifts from theory into practice, it will become both a business imperative for hospitals and private practices to provide better follow-up care and create more cohesive care teams. Case managers will be needed at the frontlines, to help clinicians manage the process.