



# Jumpstarting population health management

Issue Brief

April 2016

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# Taking small, tangible steps towards PHM for scalable achievements

As the evolution toward value-based medicine progresses, many healthcare organizations are focusing on Population Health Management (PHM) as a key to achieving improvements in care coordination and costs. However, there are challenges with understanding the breadth of PHM as well as where to start. While it is important to look at the full continuum of care and not look at PHM in silos, we do believe taking small, tangible steps, and then expanding on them incrementally, can result in scalable achievements at the appropriate pace and level.

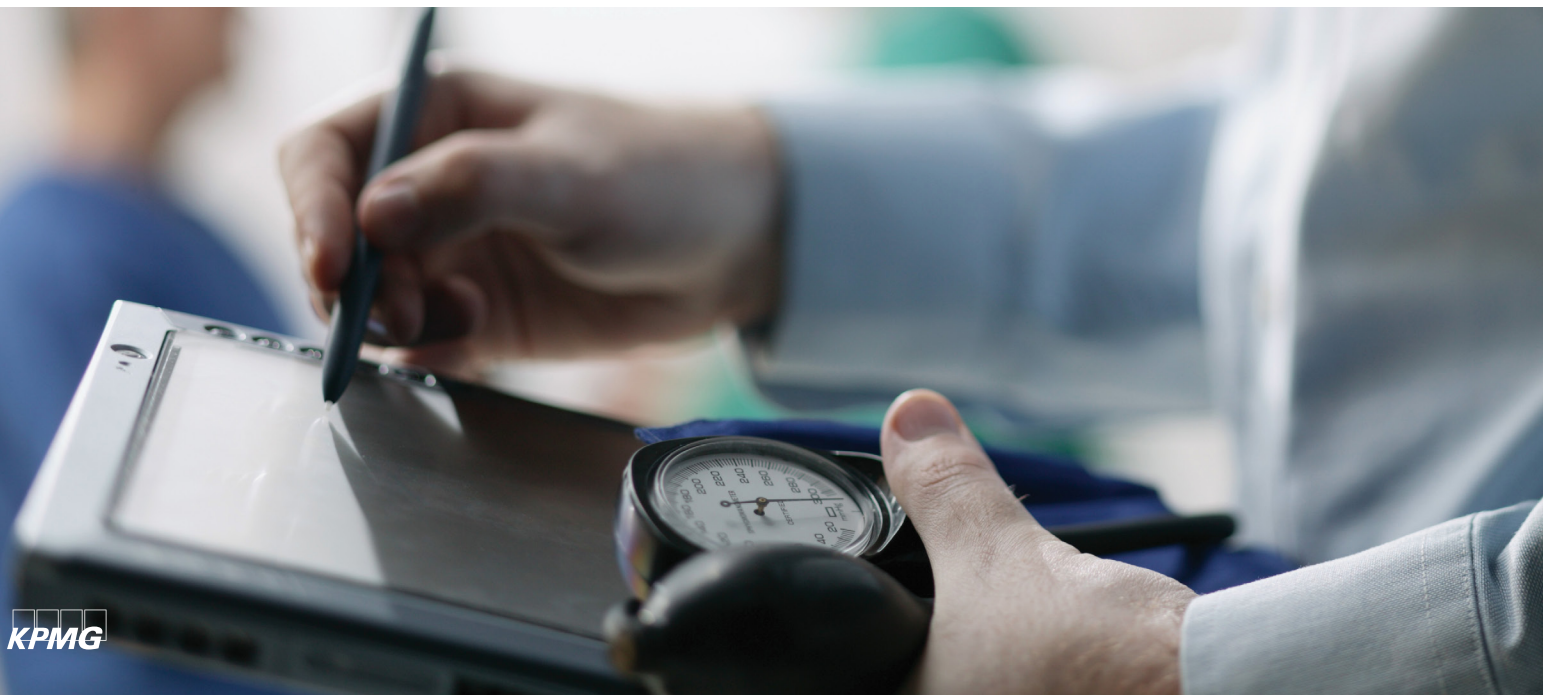
According to the *American Journal of Public Health*, population health is defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” Although that defines what population health is, we believe that managing it is a more complicated matter.

In our view, *population health management* involves using analytics to understand and stratify the specific risks and

gaps in care of the chronically ill and underserved or simply the lack of continuity of services throughout the continuum of care. Accessing longitudinal data will help us to better tell the patient story, provide a platform for standardization of care guidelines and management of patients, and allow for the population based reporting, which will provide data to evaluate and optimize the care delivered and the process by which it is delivered, identifying disparities.

Using the necessary data to target those populations and accessible services through care coordination efforts can provide optimal, proactive management of care to avoid or minimize adverse results. As a result, healthcare organizations can offer patients and consumers better outcomes, higher quality care, and lower costs through the use of effective Population Health Management strategies.

So, how can organizations best leverage PHM in order to improve clinical, financial, and operational outcomes? Here are five steps to get your organization started.





# The power of PHM: Five steps

By addressing individual gaps in care and targeting high-risk populations with preventative interventions, providers can reduce the need for such costly interventions as emergency department (ED) visits, 30-day readmissions, frequent hospitalizations, costly diagnostic tests and invasive and duplicative procedures. Through planning and implementation of a PHM strategy, organizations should focus on five specific key elements that can help address the challenges that may arise:

- 1. Identify targeted populations**
- 2. Establish realistic benchmarks**
- 3. Use technology and process improvement to accomplish goals**
- 4. Integrate care approach through the continuum of care including community partnerships**
- 5. Create effective governance structures**



## **Step #1: Identify targeted populations**

Population health outcomes are the product of multiple determinants, including utilization of medical care both preventatively and during symptom flare-ups, public health factors, socio-economic data, self-care behaviors, medication adherence, and much more. As such, it is important to deploy the best use of resources to identify and understand the needs of targeted populations. Stratifying populations can be done on the following basis:

- Level of risk (e.g., repeat emergency department [ED] visits, extended or prolonged length of stays [LOS], limited access to care, history of non-adherence to medication regimens)
- Chronic illness (e.g., diabetes, congestive heart failure, high blood pressure, asthma, chronic obstructive pulmonary disease [COPD])



- Disparities in care protocols and treatment plans
- Geographic/regional population trends
- Community health needs assessments
- Identification of priorities based upon statistical analysis

Once targeted populations are identified, in-depth analysis can be done using scoring tools, including:

- Diagnosis-related groups (DRGs), which are used to classify diagnoses of hospital patients according to the body systems impacted and then further subdivide them according to severity, comorbidity and complications for the purpose of Medicare reimbursement
- Severity-adjusted case mix index which is used to determine how resources should be allocated to meet patient needs within a diagnosis group; this accounts for severity of illness or a patient's condition
- "LACE" assessment – a popular tool used in hospitals to calculate a readmission risk score based on length of stay, acute admission through the emergency department (ED), comorbidities and emergency department visits in the past six months, predicting the risk of readmission or mortality within 30 days of hospital discharge
- Proprietary algorithms, such as those from KPMG that are based on proprietary access to large patient claims data sets and algorithms contained in population health management vendor systems
- Patient level care metrics, identifying disparities in treatment plans in comparison to outcomes



## Step #2: Create effective governance structures

Implementing an effective and comprehensive governance structure to drive change and accountability is central to successful PHM.

However, many organizations have fallen short when it comes to putting policies in place and educating staff.

The right governance structure includes defining staffing models, roles and responsibilities, backed up by endorsement from senior leadership. Governance programs should address communication of efforts and progress, ensuring care and resources are centered on the patient, involving the community, and integrating efforts across the continuum of care both inside and outside a hospital's walls.

Some key considerations when creating an effective governance structure are:

- Who will review and analyze data?
- How will this team determine priorities?
- Once risks are identified, how does communication occur that will engage Care Management team/Care Coordinators to implement measures that will avoid risk?
- How can redundancy and overlapping efforts be avoided?
- What efforts are needed to eliminate silos?
- What committees are already in place (e.g., quality, ambulatory care, policy and procedures, credentialing)?
- What has or hasn't worked well in the past?
- Is there an effective plan that orchestrates communication between health system Care Managers (inpatient and outpatient) with Physician Practices and community specialists (non-medical and medical)?





# Case Study: Taking incremental steps to develop full scale PHM

KPMG helped a large academic medical center in New England with implementing its Population Health Management Strategy and developing expanded Program Leadership.



## How KPMG Helped

- Assisted with the application submission, planning, and implementation of an IHI Triple Aim Learning Community grant which helped client secure \$50M in waiver funding round 1 and \$100M waiver funding in round 2
- Assisted client with identifying targeted populations of elderly, high risk perinatal patients, and Employees
- Reviewed organization's current state and readiness for transformation
- Evaluation of tools, process, and personnel to develop enterprise roadmap for a Population Health Management program
- Development of PHM programs to achieve improved outcomes and submission of monthly reporting to government



## Client Benefits

- Development and implementation of a Nursing Improving Care for Health system Elders (NICHE) which included improving the patient experience for the age 65+ population, established a baseline of serious reportable events, readmissions, mortality rates, average LOS, reduced healthcare costs
- Developed, recommended, and assisted with implementing best practice recommendations for program strategy, content, measurement, and implementation for high risk OB patients

- Led the development and implementation of a Wellness program for client's Employee population to increase participation by 25%, collecting biometrics data to measure outcomes
- Developed a full scale Population Health Management strategy and framework for client's continued use to target other populations through risk stratification process



## Key Deliverables

- Population Health Management program road map
- Gap assessment of current risk-management and care-delivery capabilities
- Strategy, implementation plans, PHM program framework, tools, and reports
- Education and presentation to Leadership on progress achieved and recommended next steps for PHM program expansion



## Key Areas for Improvement

- Quality: Identifying key quality metrics and mining data for a single source of truth related to the identified quality metrics, a key to implementing a performance improvement program.
- Care Management: Helped the client identify one population to focus initial care management efforts, in order to concentrate resources and create a successful model for other areas of the health system.
- Employee Wellness: Identifying appropriate incentives that encouraged patients to engage in health monitoring and health promoting activities, a critical step toward building a successful and sustainable employee wellness program.





### Step #3: Use technology and process improvement to accomplish goals

Advances in healthcare information technology (HIT) and data and analytics are automating and increasing the sophistication of population

health management efforts. Data and analytics can be used to better identify, stratify, and understand targeted populations, and to track and report metrics to improve programs. Population health tools can be used to connect treatment teams to foster continuity of care; automate workflows to maximize the use of resources; create portals to allow communication between patients, other providers, affiliates and community resources; and connect to electronic medical records (EMR) to have context for present-day healthcare decisions.

Healthcare organizations and Physician Practices can make effective use of technology to promote improved population health management among patients and consumers, especially the chronically ill. For example, they can:

- Establish chronic disease and illness registries that tracks specialized needs of patients and identifies where specialty services, treatments, and locations can be established to offer care and services to this targeted population
- Expand service offerings, clinics/mobile vans, and specialty programs in the community based upon reviewing data and understanding needs of the community (e.g., women and children health clinics, mobile behavioral health/psychiatry units)
- Create portals for patient and consumer education and communication with health team members at a hospital or physician practice
- Send reminders about scheduling appointments,

immunizations, and upcoming/overdue tests

- Provide educational materials and online support groups for those with chronic illnesses

Beyond the use of technology, it is most important to include performance improvement processes into the PHM program through a systematic approach to improve care across the continuum:

- Model out the care continuum functions and associated flows throughout the system.
- Recognize where standardization of care is needed and employ the use of evidence based guidelines for optimal outcomes and care delivery.
- Identify actionable goals achieved with data analytics by collecting baseline measurements, identify changes, followed by implementation and measure results.



### Step #4: Establish realistic benchmarks

Benchmarking is a key critical component for measuring progress internally, in order to determine whether goals are being achieved, and for comparing against other organizations nationally. When establishing benchmarks, set realistic targets that will allow you to recognize tangible results. From there, assess where the organization is now compared to benchmarks by:

- Collection and analysis of aggregate data from PHM tools or Enterprise Data Warehouse (EDW)
- Gathering clinical, quality, and financial data (e.g., EMR, claims data)
- Receiving input from staff, patients, and providers





- Using evaluation techniques (e.g., timely data, LACE index, PHM tool)

Although it varies by diagnosis, population health management can result in significant cost savings. (See chart, “Top 10 Primary Conditions by Savings Opportunity.”)



#### Step #5: Integrate care approach through community partnerships

- Tapping into the community is an effective means of taking care of patients beyond an organization’s walls. Effective care coordination

assists patients and their support network by engaging in a collaborative model. The goal of this integrative care model is to help patients achieve optimal levels of wellness and outcomes while non-duplicative services and reducing costs through admissions, readmissions, non-duplicative services and ED services. Throughout this process care teams will effectively guide and track patients and their families through the continuum of care, effectively managing their medical, social and mental health conditions.

#### Integrated care example

Mr. Jones presents to ED as uncontrolled diabetic	Given insulin and sent home	Care coach calls to ensure he schedules apt. with PCP and fills his prescription	PCP (who is a PCMH) has a care coach provide education and coaching around taking medication and checking glucose	Nutritionist ensures he’s following ADA diet	Monthly visit with podiatrist	Scheduled eye exams	<b>End Result:</b> Mr. Jones doesn’t end up back in the ED as an admission

Before community outreach can occur on behalf of individual patients, steps must be taken to develop an effective strategy and program. Organizations should:

- Conduct community-wide risk assessments
- Assess data and compile results for community needs
- Stratify targeted populations at risk
- Align programs, care, and services to meet the needs of targeted of populations
- Prioritize services and initiatives based upon results
- Develop strategic plan of multi-year programs with roles and required budgets (start small with immediate benefits and incrementally work towards more complex programs)
- Create a tactical plan (e.g., education, counseling, and preventative measures)
- Develop communication strategies both internally and externally on new programs and services (consider language and education barriers)

#### Staying Focused Drives Positive Outcomes

Putting time and effort into promoting better population health management will ultimately benefit all constituents of the healthcare ecosystem. Providers will move much closer to creating value-based care models. Payers can better measure quality and align their reimbursement rates. And patients can improve their health as they avoid ED visits, minimize hospital admissions and readmissions, learn to manage their illnesses, and understand the importance of adhering to medication regimens. And, of course, the whole system will function more seamlessly if patients know they are cared for not just during office visits, but on a consistent, sustaining basis.

# How KPMG can help

KPMG can assist healthcare clients in achieving an accelerated time to value on technology investments, while facilitating integrated end-to-end transformation initiatives. KPMG has broad-based capabilities in core provider business applications and Electronic Health Records (EHR) systems, as well as ACO development, clinical process improvement, performance improvement, and advanced analytics capabilities.

Further, KPMG understands the complex journey that hospitals and health systems must undergo to change and realize value. The firm's proprietary strategy methodology connects business model design (strategy) and operating model implementation (execution). KPMG's strategy and IT capabilities are complemented by a wide-range of implementation services through the deal advisory, management consulting, and risk consulting practices.

The collaborative experience of these practices is more than the sum of the parts. Together, they establish a platform to support transformation with deep industry experience and strong and differentiated proprietary methodologies and tools. The end result is a customer engagement where strategy, business model, and operations are all in sync.







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