A warm welcome to the Fall Semester! To our new students and faculty, we are happy to introduce you to the ‘Monday Dose,’ a monthly publication that is read by alumni, students and faculty of our College. Each issue addresses an important and timely professional development topic that will stimulate and enrich your learning experience. This month’s issue is about *Population Health Management*, an approach to population health that can potentially lower health care costs and increase quality. Although not new, the concept is now enshrined as policy in the Affordable Care Act and increasingly popular in the private sector. As public health professionals, we need to understand and promote it. Happy reading and have a great semester!

“A Few Quotes for Your Thoughts”

“America’s healthcare system is in crisis precisely because we systematically neglect wellness and prevention”—Tom Harkin

“Today the demands are for even higher standards in the quality of care, for greater flexibility and convenience in treatment times, and for more prevention through screening and health check”—Lucy Powell.

“The doctor of the future will give no medicine, but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease”—Thomas Alva Edison.
In Population Health Management, individuals must be evaluated to identify their place on a continuum of health risks. Specific interventions are then targeted to people based on where they fall on the continuum of risk/care. This article depicts patient-centered care in practice, and how it can decrease utilization of health care services and lower total annual charges.

Bertakis KD & Azari (2011). Patient-centered care is associated with decreased health care utilization. JABFM 24(3), 229-239. [Website](http://www.jabfm.org/content/24/3/229.abstract?ijkey=cfcf271a60cc5794e9adca752b81e0107a3853a2&keytype2=tf_ipsecsha)

Population Health Management requires organizations to fully engage patients in their care. Electronic Health Record adoption is only the first step toward creating the requisite infrastructure; but automation of much of the process of care including identifying gaps, patient outreach, patient education, and care management, is a necessary and cost effective tool for PHM. This article takes a look at the many ways in which automation can be used to facilitate the population health management process.


This article takes an early look at statewide efforts in Michigan, Massachusetts, Washington and Ohio to reduce rates of avoidable re-hospitalizations. Called the State Action on Avoidable Re-hospitalizations Initiatives, the efforts involve 148 hospitals working in partnership with 500 providers and community agencies with which the hospital frequently shares patients. This article depicts the importance of partnerships and leadership in population health management.

Boutwell et al (2011). An early look at a four-state initiative to reduce avoidable hospital readmission. Health Affairs, 30(7), 1272-1280. [Website](http://content.healthaffairs.org/content/30/7/1272.full)
Population health has been defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. Population health management (PHM) aims to ensure that a population remains as healthy as possible, thereby diminishing the need for costly care. Key components of PHM include community outreach, coordinated care for patients, patient education and counseling, and intervention strategies addressing the specific needs of targeted population groups. While PHM is not a new concept, it is becoming a core competency of health services administrators. As the reimbursement system changes, from fee-for-service to fee-for-value (i.e., payment based on outcomes of care), organizations are looking for ways to improve quality and save costs, and they are turning to PHM for answers!

**What IS Population Health Management?**

- At its best, PHM is a collaboration among health care providers, public health agencies, schools and other local organizations.
- Factors that influence population health include medical care, the physical and social environments, genetics and individual behaviors. Therefore, PHM must address all of these factors when developing health interventions.
- PHM facilitates regular contact between individuals and their primary care providers in order to support preventive and chronic care delivery.
- PHM enables a transition, or continuation of care, from the hospital setting back into the community.

**Enablers of Population Health Management**

- Development of integrated health care delivery models and of reimbursement mechanisms that incentivize integrated care and population health.
- Accountability clearly outlined across the care continuum.
- The use of joint decision making between patients and providers.
- Transparency and flow of information among providers for a complete picture of a population’s health.
- Increasing patient engagement to ensure they understand and can better manage their health.

Sources:
Mayo Clinic Health Solutions offers resources ranging from health awareness to educational tools. [http://www.mayoclinichealthsolutions.com/products/products-main.cfm](http://www.mayoclinichealthsolutions.com/products/products-main.cfm)

CDC’s Healthy Communities Program offers the CHANGE Tool to help prioritize community needs. [http://www.cdc.gov/healthycommunitiesprogram/tools/change.htm](http://www.cdc.gov/healthycommunitiesprogram/tools/change.htm)

The Care Continuum Alliance has developed Essential Population Health Management Tools for Accountable Care Organizations, and other products. [http://www.carecontinuumalliance.org/](http://www.carecontinuumalliance.org/)

Mobilizing for Action through Planning and Partnership (MAPP) is a strategic planning and community health improvement tool. [http://www.naccho.org/topics/infrastructure/mapp/index.cfm](http://www.naccho.org/topics/infrastructure/mapp/index.cfm)

### Why is Population Health Management Growing?

- **Accountable Care Organizations (ACOs)** – are looking to cut healthcare costs while improving health outcomes of the populations that they serve; PHM is a great approach for balancing cost and quality.
- **eHealth** – technology has driven the utilization of PHM tools (Electronic Health Records have the potential to be integrated into a system that can track the health of a population).
- **Reducing hospital readmissions** – the ability to track and analyze data on the reasons behind avoidable readmissions will lead to their reduction.
- **Dual eligible** – as more Americans become eligible for Medicare and Medicaid, the costs for these services increase; using PHM tools can help reduce these costs.
- **Federal support of prevention and wellness** - $15 billion was allocated to the Prevention and Public Health Fund to support population health.
- **Health Insurance Marketplaces (Patient Protection and Affordable Care Act)** – PHM has the ability to help these exchanges achieve their goal of affordable healthcare services.

### Key Elements for Successful Population Health Management?

1. Information-powered clinical decision-making.
2. Primary care-led provider teams.
“Ask the Professors”

**Question:**
What are the one or two most important features of population health management that public health students should know about? And how will this knowledge be useful to our public health graduates?

**Answers:**
One of the most important things that students should know about population health management is that “population health” and “public health” are not the same thing. This is because “population health” is framed around the particular population that the organization serves or targets. For public health agencies, the population served may be bounded by geography, jurisdiction, or city lines, whereas for health care delivery systems, the population served is defined by the potential client population and may stretch across county or state lines.

Much of your career now and in the future will be defining population health and incorporate population health management tools into the vision and goals of your organization.
Increasingly, the focus of healthcare in the U.S is shifting from traditional interventional medicine to wellness and prevention. Consistent with this changing focus, reimbursement in healthcare is increasingly based on attainment of quality objectives, rather than volume of care for an entire population. This makes population health management an important subject to understand. Public health graduates should appreciate key features of population health management: indicators of health status of a given population, collaborative teams, and evidence-based-interventions.

Health status indicators, such as tobacco use and obesity, determine key health issues such as heart disease and cancer. Over the years, several health interventions have emerged; however, public health professionals should only identify those interventions that have been proven effective and cost-efficient. By their nature, evidence-based approaches usually integrate the continuum of healthcare services and must be delivered by collaborative teams. Public health professionals must therefore be prepared to collaborate with other professions in population health management.

The Affordable Care Act (ACA) requires hospitals to maintain the health status of the populations that they serve. This has generated the need for community health assessments by hospitals. An understanding of population health management issues is thus important for public health graduates, particularly those interested in working with healthcare organizations. Such knowledge will prepare graduates to contribute to emerging models of care, especially Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs), which utilize a range of population management tools including integrated care, collection and analysis of health outcome data, monitoring of population health, community engagement, and global budgeting.
I think students should understand the concept of population health management in the context of three environmental forces that are changing the industry.

First, Medicare expenditures are set to rise dramatically due to the enrollment of Baby Boomers – 77 million people born between 1946 and 1964 – in the program and longer life expectancy. The Congressional Budget Office (CBO) estimates that “the aging of the population will cause spending on the major health care programs and Social Security to rise significantly. In fact, during the period, almost all of the projected growth in such spending as a share of GDP is effectively the result of aging.” (http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf). The Center for Medicare and Medicaid Services (CMS) estimates that the number of Medicare beneficiaries is expected to grow from 50.7 million in 2012 to 81 million in 2030 (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf).

Second, information and data are increasingly available. These data sets can be used to support comprehensive patient care that promotes efficiency and effectiveness. The key will be to provide care that is proactive and preventive in nature. While this is not a new concept – case management has been used in high-risk patient populations for decades – the application to a broad population base is becoming more reasonable due to data availability.

Third, the incidence of chronic disease – e.g., heart disease, stroke, cancer, diabetes, and arthritis – is increasing and approaching epidemic proportions. Chronic diseases are the leading cause of death and disability in the US, accounting for 70% of deaths each year. Heart disease, cancer, and stroke account for more than 50% of all deaths each year. (http://www.cdc.gov/chronicdisease/overview/index.htm)

These environmental forces are pushing healthcare providers/managers to a new paradigm focused on cost containment and risk sharing (see Accountable Care Organization and Medical Home models). Understanding these dynamics, regardless of student concentration or type of organization employed, will be critical for MPH students.
October 1 – Breakfast with the Expert with Mary Vance, Executive Director, Mountain Home Good Shepherd Clinic, Sevierville, TN, Lamb Hall Room 116 at 8:30 am

October 3, 10, 17, 31 – Farmers Market

October 14 – Fall Break

October 16 – Health Professions Recruitment Fair, DP Culp Center Ballroom

October 18 – Grand Rounds, Dr. Charles Stuart, Lamb Hall Room 116 at noon

October 23 – Career and Graduate School Fair, Millennium Center

October 24 – Leading Voices in Public Health lecture, John Hoffman, Culp Auditorium

October 31-- Special Lecture, John Sanders, Bioterrorism: Implications for Public Health, DP Culp Center, Forum Room