



Population Health: How Healthcare Leaders Are Re-envisioning Data Integration and Care Management

Nelson, DHA, MBA, chief innovation officer at Millennium Physician Group (MPG), an independent practice with 465 providers responsible for more than 365,000 patients. In addition to the ACO, MPG also offers pharmacy, lab, and imaging services.

Nelson says MPG's carefully planned and executed population health model contributes to the ACO's strong performance in MSSP Track 3, which includes both upside and downside risk. "We are focusing on reducing waste, overall

spending, and how we can manage patients differently to keep them out of the ER and the hospital," he says.

Similarly, Western Connecticut Health Network (WCHN), a three-hospital health system with 600 employed providers and a physician hospital organization in Danbury, has doubled down on its population health strategies in the last few years. It too has an ACO that participates in MSSP, and its network has entered into value-based contracting for providers. In particular, WCHN is developing work flows that integrate care and access solutions across inpatient and outpatient settings. "We are focusing on building care paths and disease management programs," says Michelle Zelek, director of population health operations. "It is not just about partnering with primary care providers on the ambulatory side, but changing how we care for patients across the entire continuum."

In 2017, Fort Myers, Florida-based Millennium ACO earned more than \$29.7 million in shared savings through the Medicare Shared Savings Program (MSSP), making it the No. 1 performing ACO for percentage of shared savings, according to organization leaders. In fact, for five years running, Millennium ACO, which has 56,000 attributed patients, has earned shared savings, says Jeffrey

As provider organizations take on risk and quality-based contracts through ACOs and other payer models, they must carefully consider the next stage of their population health management journey. Nelson and Zelek agree that population health trends are changing. "Population health used to be about care management. Now it has shifted to being more about analytics, understanding data trends, and then tying in care management," says Nelson. Zelek, who oversees data management, also sees the data shift, noting that the goal has moved from creating standardized reports on clinical and financial performance to giving insights to providers at the point of care.

Below, Nelson and Zelek share key population health strategies and tactics, including how to become a data-centered organization, provide better support for physicians and care teams, and deliver accurate and actionable information at the point of care.

Millennium Physician Group: Leveling up on data analytics

Creating a patient-centered ecosystem with a strong data foundation is top priority at MPG. With the support of its high-performing care management team, an enterprise data warehouse, and an integrated population health management platform, not only does MPG track and develop care protocols for its top 5% highest-risk patients, it is also ensuring data is aggregated and shared with care teams across all settings quickly and concisely.

“It is about managing that provider-patient relationship, augmenting our providers with care teams and case managers, and really understanding what the data is telling us,” says Nelson. “We are taking a 360-degree view of the patient and moving from episodic to longitudinal care and structuring the EMR so providers can get data into the ecosystem.”

Nelson says Millennium’s data transformation started many years ago. “Today, we are at the back end of the data maturity model,” he says. The result of this journey is a shift from being an EMR organization to one that is data centered. “Our ACO performance shows we are honing in on data and aggregating it to support physicians with care teams when they are not at the point of care.”

At the same time, MPG’s population health platform plays an integral role in collecting, analyzing, and sending critical information to care teams. The platform feeds directly into the Florida HIE, which is connected to the majority of state hospitals. The system triggers automated alerts when Millennium patients present at other hospitals. “If a patient has a hospital ER event, we will get notified in real time and know what they came in for and why they were discharged,” says Nelson. A care team will jump into action, communicating information about the visit to primary care providers.

“We found 30+ percent of hospital visits were because the patient was lonely. An ER visit wasn’t needed,” he says. With this data, the organization has established preventive measures and protocols for redirecting patients to the proper care setting. “The immediacy of the information and the ability to send data to the proper person at the right time has helped reduce ER visits,” Nelson adds. Moreover, the group is looking at how technology can better support care teams and patients in managing chronic conditions. It offers telehealth and remote patient monitoring. The group also recently developed an app for its care teams that looks at current patient medications, and plans to roll the app out soon to patients. Nelson says several more patient-focused initiatives of a similar nature are in the works over the next six months.

WCHN: Transitioning to complex care management

WCHN spent the last few years redefining its population health program. “At the start, population health was more of a concept for physicians who had value-based care contracts and worked in the ACO, but we needed more defined structure,” says Zelek. “We have spent a lot of time restructuring our population health department and defining population health opportunities. The purpose is not just to define roles and responsibilities but to also create an external understanding of what population health is and how it integrates into our network.”

Zelek says both care and data management are critical focal points, noting that when WCHN first created a population health program, the goal was to improve how the organization managed care

transitions from acute care settings. The program was built around managing five specific patient DRGs, she says. “This is very important, and we still do it today; however, as we go down the path of value-based care, managing patients out the door of the hospital is not enough to perform well or to care for patients and prevent them from coming to the hospital in the first place.”

Now, WCHN is transitioning to a complex care management model. “Our goal has been to shift from just managing patients in the acute care setting with transition back into the community to capturing the rising risk in patients before they need hospitalization,” says Zelek. Data analytics are a key part of this change. WCHN’s population health platform provides patient risk scores, enabling it to capture patients who are at higher risk for an ER visit or hospital admission. The risk model provides insights about care utilization, social determinants of health, census blocking, and more.

“We use it as a way to capture the right population prior to an acute event. It looks at various indicators that tell us when a patient will benefit most from care management,” says Zelek. She adds that the ultimate goal for the care management program is to become NCQA certified to allow for delegated agreements with payers.

Zelek says WCHN is making significant progress in advancing population health programs and goals, including providing targeted support for physician practices through centralized extended care teams and strategic embedding of care team members. For example, the population health platform flags patients who are taking multiple medications and shares the information with pharmacists who are now embedded in various primary care practices. The organization also placed palliative care team members in ambulatory settings to identify patients who would benefit from such care. “The program is powerful because it is hard to ask providers to do one more thing,” says Zelek. “However, when you say to a provider, ‘This is your list of 40 patients who would benefit from a palliative care program,’ it is a game changer.” ■