Population Health Management Tools and Strategies
to Support Care Coordination

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Recent efforts to reform the American health care system focus on improving the health of designated communities or populations, and purchasing health care services based on value and improved outcomes. New service delivery models are expanding and include Health Homes, Accountable Care Organizations, Federally Qualified Health Centers, and Certified Community Behavioral Health Centers, among others. Effective population health management requires tools and resources that support the identification and prioritization of individuals who are at-risk for poor health outcomes. Outcomes of care are improved through services that are integrated across the spectrum of physical and behavioral health and effectively coordinated.

Many health care organizations have a wealth of patient and population level clinical data, yet they are at a loss for how to understand and use this information to improve care outcomes. Additionally, the complexities of data related to behavioral health and chronic conditions further confounds the use of this information for the identification and care coordination of high risk-individuals. The results are systems of care that are ill equipped to provide comprehensive care coordination and contract for value-based population level health outcomes.

InfoMC recognizes the importance of taking large aggregate health information data sets and translating them into actionable information that supports guidance for health outcomes improvement. This approach is based on the recognition that there are many key drivers of high health care costs and low health outcomes. Behavioral health conditions and their influence on health outcome are frequently not well understood, and must be a cornerstone of any population health outcomes strategy.

The effective identification of individuals who are at risk for poor health outcomes can inform providers of their patients who have high costs and are likely poorly managed across systems of care. It is common for individuals with poor health outcomes to be seen across a variety of providers, facilities, and among a range of community based social service systems. As a result much of the care that these individuals receive is fragmented, poorly coordinated, and ineffective.

A comprehensive strategy for population health management requires four key steps. These include:

- The identification of at risk members of the population who are either currently experiencing poor health outcomes or likely to in the near future;
- The stratification of members of the population who are most able to benefit from coordination of care and the integration of services;
The capacity for analytics to better determine the key attributes of members of the population who are experiencing poor health outcomes and what the contributing factors may be; and

Effective care coordination strategies and resources to foster integration among providers that support person centered care.

InfoMC’s InSpotlight tools provide resources for the use of broad population health data and filtering tools to translate key factors of chronic health and behavioral health conditions into care management strategies. Methodologies for the identification of at risk patients include both standard sets of rules and customizable filters for determining at risk members of a covered population. Together these resources help identify both the physical and behavioral determinants of health outcomes and the overall wellbeing of the populations served.

Within the population determined to be at risk of poor health outcomes InfoMC’s InSpotlight tool helps to prioritize the key patients who are most likely to benefit from enhanced care coordination services. The identification of at risk populations and the determination of likely candidates for enhanced services are also augmented by a suite of analytic tools that help inform targeted quality initiatives and focused care coordination services.

Many health systems are overburdened with health services data that is not useful, and generally ineffective for the improvement of care outcomes. Additionally, when the covered population receives care beyond the scope covered by existing electronic health records, the capacity for data analysis and coordination of care resources is limited or nonexistent. These systems also fail to integrate physical and behavioral health data, and are unable support care coordination for individuals with co-morbid conditions. InfoMC’s InSpotlight tools use evidence-based indicators to translate selective health care data into actionable care coordination workflows.

A comparison between EHRs and the functionality of health management systems demonstrate the necessary functionality to successfully manage population health outcomes. Additionally, health management systems also foster effective care coordination and the integration of care across providers systems and community based resources.
Care coordination is key for translating population health data into actionable services that improve the health outcomes of covered populations. InfoMC’s InSpotlight population health tools provide aggregated identification and stratification reports which are presented via dashboard resources and supports InfoMC Incedo care coordination workflows. Effective care coordination addresses the existing gaps in patient care, transitions between services and levels of care, and the challenges to an individual’s community tenure. Well-coordinated care ensures that both physical and behavioral health needs are addressed and integrated among all providers. The Agency for Healthcare Research and Quality (AHRQ) describes Care Coordination as “deliberately organizing patient care activities and
sharing information among all the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.” (AHRQ, 2016)

The goals of effective care coordination services are to identify those individuals who are at risk for poor health outcomes, and provide resources that help integrate care and support member engagement in health services and activation for improved well-being. Five key elements of care coordination have been identified and include:

- **Numerous participants who are typically involved in care coordination;**
- **Coordination is necessary when multiple clinicians and services are dependent upon each other to carry out disparate activities in a patient’s care;**
- **In order to carry out these activities in a coordinated way, each participant needs adequate knowledge about their own and others’ roles, and available health and social service resources;**
- **In order to manage all required patient care activities, participants must rely on exchange of information; and**
- **Integration of care activities has the goal of facilitating appropriate delivery of health care services (McDonald, Sundaram, Bravata, et al., 2007).**

Some of the root-cause problems of poor care coordination include: information sharing among provider systems with different electronic health records and systems; the difficult challenges that many hospital systems have to effectively transmit information to all physician offices involved in a patient’s care; the failure of primary care providers to know that transitions in care have occurred; poorly communicated results of specialty services referrals/consultations; and, limited or few financial incentives or penalties for the failure to transmit information that would support care coordination (Burton, 2012). The coordination of care and the integration of services at the provider level has demonstrated improved population health, clinical outcomes, and cost savings.

Care coordination requires resources that promote the exchange of information across diverse provider, payer, and services platforms. This includes linking multiple sources of data including eligibility, claims, service authorizations and utilization, pharmacy, laboratory and other information sources. The integration of these disparate data sources allows for the analysis of the covered population for the identification of individuals at risk for poor outcomes and targeted interventions.
The central goal of care coordination is the use of these data points for engaging individuals within a population to promote improved health outcomes. This is accomplished through care plans that are auto generated with actionable data, workflows that are driven by evidence based assessments, person centered goals, and monitoring progress towards outcomes.

Successful care coordination models adopt technology platforms that bridge the data sharing gaps across multiple provider systems, and establish work flows that direct and support the full spectrum of health care, social systems, and all other stakeholders who care for individuals. Improved outcomes and reduced health care costs are achieved through the following operational efficiencies:

**Costs of Care** are reduced through effective coordination of services and resources. The reduction of unnecessary service utilization including hospital and emergency department admissions are achieved when care is integrated among providers and systems.

**Organizational Efficiencies** are realized when technology resources are leveraged to support all members of the care team with timely information and effective work flows. Care coordination technology is able to support all providers across physical and behavioral health care, and social systems.

**Quality Improvement and Compliance Management** are promoted through care coordination staff and technology resources that are focused on improving outcomes, reducing costs, and maintaining clinical standards. Standardized quality metrics can be applied to monitor the process and outcomes of clinical services.

**Effective Outcomes** are achieved when care coordination fosters services that are integrated, evidence-based, and medically necessary. Quality based outcomes are promoted by care coordination workflows that support integrated care teams.

Improved population health requires health systems to adopt tools and resources that allow them to collect data from a variety of sources to better understand those served. This goes well beyond the health records of individuals, and includes both those who are active in treatment across multiple settings as well as others who may not be adequately engaged in care. The analysis of population based data fosters the identification, stratification, and analysis of key opportunities for better care coordination. Patient-centered care coordination improves engagement, activation, and fosters improved health outcomes. This is accomplished through improved communications among providers and facilities, better coordination across level of care transitions, and the reduction and avoidance of unnecessary facility and service use. The results of effective care coordination are the improved health outcomes of both the individual patient as well as the populations served.
InfoMC supports a new generation of care coordination that lowers cost and improves health outcomes through the integration of timely information from actionable sources. This promotes proactive engagement and coordination with all stakeholders including patients and their caregivers, providers and facilities, and community supports. Automation in the care coordination process fosters increased efficiency in workflows, improved productivity among providers, and informed and shared decision-making. Auto-generated care plans that are compliant with existing federal, state, and regulatory quality standards are prepopulated with person-specific problems, interventions, and goals. This assures engagement in the care coordination process, activation for adherence to care plan goals, and improved health outcomes.

About InfoMC

InfoMC Inc. is a leading provider of cloud-based healthcare management and care coordination software designed to help close gaps in health care systems. InfoMC offers a suite of rules-based workflow, data exchange, and analytics products to health plans, managed care organizations (MCOs), health systems, and state, county and community health centers and programs. The InfoMC Coordinated Care Solution provides tools for optimal care coordination of complex or chronic physical and behavioral health conditions and populations, resulting in improved quality and cost of care outcomes. The solution is designed to enable care teams – across multiple providers and stakeholders – to play an active role in the patients’ plan of care. With InfoMC solutions, our customers receive comprehensive, sophisticated functionality that eliminates costly administrative and clinical process inefficiencies while promoting improved quality and cost outcomes.

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