eBOOK

Managing the financials of population health

Challenges and solutions

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IMO Intelligent Medical Objects

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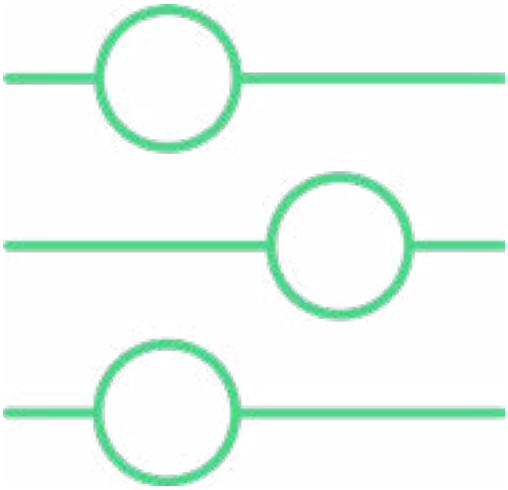
Introduction

Delivering quality care at a reasonable price is a balancing act – made even more difficult as the healthcare industry moves from a fee-for-service model to value-based care. This transition introduces new financial hurdles into today's healthcare system, as it changes how reimbursements are calculated. The fee-for-service model typically has a linear connection between the service provided or care administered and its corresponding cost. In the value-based care system, however, this dynamic changes since reimbursement is determined in part based on overall patient outcomes, not solely on the specific services rendered. Examined below are five of the top challenges institutions face when trying to manage the financial side of this paradigm shift – particularly in the context of population health – along with some solutions to consider.



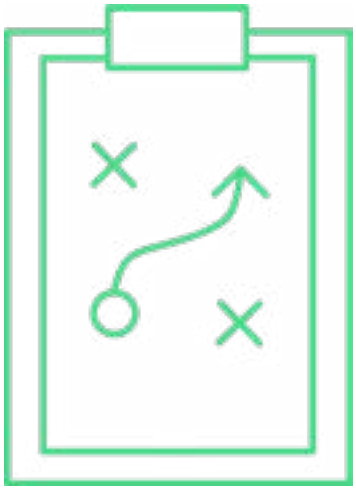
01

Defining terms

Clearly defining important terms is one of the first challenges many health systems face when designing a population health management program. It's often an unexpected hurdle, since it is easy to assume that everyone understands the basics. However, what's critical is defining terms *as they relate to the project at hand*. For example, the phrase *population health* can have multiple meanings depending on the institution or community. Or, contemplate the general diagnosis of *diabetes*, which includes individuals with type 1 diabetes, type 2 diabetes, or gestational diabetes – three different manifestations of the same overarching diagnosis that require different interventions.

Consider the following...

It may be a laborious first step, but taking time to clearly define the parameters of key terms within the context of your project will pay dividends down the road. Furthermore, soliciting input from all departments helps ensure that everyone is on board with inclusion and exclusion criteria, setting the stage for a multi-disciplined, collaborative project.



02

Thoughtful planning

The success of population health initiatives often results from identifying appropriate interventions early on and creating a road map to achieve the ideal outcomes. Planning for continual self-assessments and frequently monitoring results allows organizations to stay on track and make small adjustments as necessary to assure proper reimbursements and successful interventions.

Consider the following...

Think in reverse. Early planning for the storage and analysis of large amounts of data from multiple sources, like third-party payers and disease registries, helps projects run smoothly. Brainstorm with the population health management team to understand what ideal outcomes would be, but also what is feasible given the circumstances and resources of both the population and the health system as a whole.

03

Shifting mindsets

Providers are trained to address immediate, clinical needs before focusing on larger, population-level issues. However, successful population health programs place equivalent importance on long-term outcomes *and* individual patient care. Asking clinicians to equally prioritize both individual, immediate patient care along with overarching population health goals is usually untenable given their workloads. Indeed, doing so may ultimately result in poorer, rather than improved, outcomes.

Consider the following...

Develop a two-tiered approach by creating separate teams to focus primarily on either patient care *or* on population health. Clinical providers are the natural fit to track individual patients, whereas public health professionals and social workers are better equipped to assess the larger, population-health picture. This breakdown of responsibilities helps encourage proactive patient engagement, which ultimately supports cost-effective and appropriate care.

04

Reliable reporting

Using accurate, appropriate information is critical to understanding and managing the health of a specific population. Therefore, collecting trustworthy data is of paramount importance. However, since both clinical and claims data are needed for analyzable reporting, data is often initially incompatable, as it is gathered from several sources and in varying formats. Making sure data capture is consistent, useable, and accurate is a challenge that health systems must overcome in order to avoid the risk of making clinical decisions for large groups of patients based on erroneous conclusions drawn from bad data.

Consider the following...

Healthcare systems can only make positive adjustments to care plans if their data provides accurate insights into how health is improving or declining for a given group. Setting up rigorous standards for data collection at the outset by creating a data dictionary – a document defining how to collect information for each variable – will generate data that health systems can feel confident using for population health decisions.

05

Financial changes

The fee-for-service model used a straightforward formula: render service, receive compensation for service. Not only was the model simpler than its outcomes-based counterpart, but it also meant reimbursements were paid relatively soon after a patient received care. With an outcomes-based model, the long-term health of patients and populations plays a significant role in determining how much hospitals get paid. As a result, reimbursements are more complex to manage, which may result in payments taking longer to arrive.

Consider the following...

A health system's finances are another place where data is key. Without accurate information, complex claims can easily become a nightmare to process – leaving hospitals with empty pockets despite the care provided. Clear documentation throughout the care process can help organizations ensure that even though payment schedules are being adjusted, claims are less likely to be denied, supporting an appropriate financial return for care.

ABOUT THE AUTHORS

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June is IMO's Director of Terminology Mapping, providing HIT subject matter expertise while overseeing the daily operations of code mappings for IMO's terminology solutions. Prior to IMO, June was the Professional Practice Director at AHIMA, where she was responsible for content development and technical reviews of the Association's products and resources. June obtained her master's in health informatics from Northeastern University and her Health Information Management degree from Indiana University.

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About Intelligent Medical Objects

At IMO, we are dedicated to powering care as you intended, through a platform that is intelligent, intuitive, and intentional. Used by more than 4,500 hospitals and 500,000 physicians daily, IMO's clinical interface terminology (CIT) forms the foundation for healthcare enterprise needs including effective management of EHR problem lists, accurate documentation, and the mapping of over 2.4 million clinician-friendly terms across 24 different code systems.

We offer a portfolio of products that includes terminologies and value sets that are clinically vetted, always current, and maintenance-free. This aligns to provider organizations' missions, EHR platforms' inherent power, and the evolving vision of the healthcare industry while ensuring accurate care documentation and administrative codes. So clinicians can get back to being clinicians, health systems can get reimbursed, and patients can more easily engage in their own care. As intended.

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