INTELICHART

Engagement to Outcomes

White Paper: Patient Engagement Empowers Population Health

This educational resource is intended to help healthcare professionals understand how to strike the right balance between automated and manual patient engagement as part of a population health management initiative.

Main points:

- Chronic disease a physical and financial affliction
- Tailored patient engagement leads to better outcomes
- Defining risk with data
- Aligning population health management with value-based goals

Patient Engagement and Population Health

Intro

The U.S. is the leader in healthcare spending, yet we trail significantly in health outcomes when compared to other countries. Additionally, the industry is experiencing a continued increase in costs, leading to compromised care. Many patients are hesitant to visit their physicians due to expensive bills and high deductible plans, but more often, deferred care can ultimately cause higher long-term expenses for patients, payers and providers.

Consider the steady increase in chronic disease. It's the leading cause of death in the U.S., and it's a significant driver of costs. In fact, $3 out of every $4 spent on healthcare in our nation goes toward chronic disease. Our population is sick, and it's become both a physical and financial affliction.

With five percent of the population consuming almost half of all healthcare costs, it's no surprise the industry has embraced a population health management approach. It's critical that we engage the highest risk populations so we can improve care outcomes while also driving down costs. These population-based goals are even more important in today's environment of value-based care.

This trend isn't slowing anytime soon. Value-based care models not only apply to the Centers for Medicaid and Medicare, but also commercial payers.

With costs increasing and reimbursements hinged on care quality and outcomes, the ability to effectively manage risky populations is tantamount to the future of healthcare.

Patient Engagement Leads to Better Outcomes

In news articles, conferences, sales materials and boardrooms, the terms "patient engagement" and "population health" are abuzz. Yet more than a buzz word or trend, these initiatives are fundamental components of a healthcare organization's success. They're not just independent concepts or line items on a meeting agenda. Patient engagement and population health are interconnected, with proper engagement strategies effectively driving population health goals.

Patient engagement plays a crucial role by reminding and encouraging high risk patients to come in for regular visits and follow up appointments. Activated patients who feel more connected to their care are more likely to adhere to treatment plans, which drives better outcomes. [1] An important part of population health management – and value-based care – is the ability to keep patients healthy outside of the care visit. This is where patient engagement has the power to elevate population health management: From identification of high-risk populations to activation of those populations.

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Defining Risk with Data

Population health can feel daunting when health leaders face overwhelming amounts of data. Yet if you have access to the right data, you can better define risk. Data can be collected from any clinical source including your EHR, clinical document data, patient generated data, claims data and other data partners.

While clinical data is important, it makes up only 20 percent of the factors that determine health. Supplement your clinical data by aggregating physical environment information including where a patient lives and the type of housing they have, health behavior information such as diet and exercise, stress factors, and alcohol or drug use, and socio-economic information like education level, employment and income.

Once you are equipped with the right data, it's important to define your own risk factors based on the objectives you've set for a particular patient population. For more in-depth risk calculations, you can leverage third-party risk analysis companies. For example, a credit vendor can help determine the patient's ability to pay. Other data asset vendors can determine which patients are likely to take on additional healthcare expenditures based on their demographic and disease profiling. Reviewing historic health information helps calculate the patient's likelihood to readmit.

After defining and assigning risk categories, a population health tool can run those criteria against the selected population. This allows you to then assign more intensive management to the highest risk patients.

Engage with Balance: Manual and Automated Interventions

Population health management is by and large driven by manual resources and care teams. Care managers, patient coaches and care coordinators physically go out into the community to reach and engage patients through personal interventions, which yield great results, but are riddled with costs.

The key to successful population health management is to complement those manual resources with automated intervention tools. With detailed data filters, you can hone in on the highest risk patients (typically about two to three percent of the population and assign those to case managers for manual outreach. Low risk and rising risk patients can be managed through automated interventions. Automation can help modify patient behaviors, motivate and improve care compliance, deliver educational resources, remind patients of upcoming visits, and provide much-needed guidance between those visits.

Think about medication adherence alone. Currently, for every 100 prescriptions filled only 50–70 are actually picked up at the pharmacy. Of those, only 25–30 are taken properly. [2] With a combination of discharge and follow up instructions, medication reminders and ongoing outreach, you can improve medication adherence. In fact, in a study of 2,742 patients, text messages doubled the likelihood of adherence among patients with chronic diseases. [3]

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By integrating population health management with patient engagement, you can tailor your engagement strategies to the individual. An older patient may respond better to mailed postcard or letter reminders, while a younger patient may act quickly upon receiving a text message reminder. With the ability to supplement manual activities and resources with automated tools, you can alleviate costs that could be otherwise allocated to manage the highest risk – and hardest to reach – patients.

With each population and subpopulation identified from the beginning, and with goals set for each, you can track each patient population against your objectives. Whether you want to align efforts with a quality payment program, reduce hospital admissions or increase adherence, it's important to track your performance and adjust care management as needed to achieve those goals. Monitor each patient population against your goals and engagement activities so you can easily discover where the gaps exist. With visibility into each population and their responsiveness to automated versus manual interventions, it's possible to strike the right balance between the two.

A Partnership in the Making

It's clear patient engagement and population health go hand-in-hand. It's important to look for population health solutions that sync with your patient portal for easier communications and scheduling, and integrate with other engagement solutions, like text messaging, automated phone calls, mailers and others. Population health management should align with value-based-care goals, and to do so effectively, healthcare organizations must be able to reach patients outside of the care facility.

Patient engagement is a crucial element of population health, which can best be deployed with a balance of manual and automated tools. They should not be viewed as siloed initiatives, but rather two complementary approaches to improve outcomes and lower costs.

Learn more about how population health tools can help you manage your patient populations by scheduling a demo with INTELICHART.

This Resource was Created by INTELICHART

INTELICHART empowers healthcare providers with the technology solutions they need to create healthy outcomes for patients. INTELICHART offers its HealthyOUTCOMES Solution Suite to facilitate patient engagement, health information exchange, and population health with a robust API that integrates with more than 25 leading EHRs. The HealthyOUTCOMES Solution Suite is enhancing the patient experience for more than 30,000 healthcare organizations. INTELICHART was founded in 2010 with the mission to improve the health of patients outside of their office visits, and its employees are innovating every day with that mission in mind.

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[1] http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0179865#sec012

[2] https://www.nacds.org/pdfs/pr/2011/PrinciplesOfHealthcare.pdf

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5561384/