

# Population Health NEWS

## Importance of Well-being, Mental Health Are Catching on—and for Good Reason

by Shawn T. Mason, Ph.D., L.P.

**T**he psychological factors that impact overall human health and well-being have been largely ignored as a critical opportunity in healthcare. A growing body of research evidence and commensurate market growth suggests this is starting to change. This gap could start to close and transform the way health and well-being are addressed in healthcare delivery and the products and services used to improve individual's overall functioning.

The historical focus of population health has largely been based on chronic conditions, such as diabetes, heart disease and arthritis, and their associated costs; however, health and well-being are now being studied more often together and on a larger scale. Research literature consistently shows an important relationship between well-being and mental health and how they can influence or be affected by a myriad of health factors, including obesity, cardiovascular disease and longevity.

Much of the past research around well-being resides in medical literature and focuses on the impact of various medical conditions on quality of life (QOL), an issue closely related to well-being. This can, in part, be due to early well-developed measurement tools, such as the Rand Short Form 36<sup>1</sup>—a set of generic, coherent and easily administered QOL measures. However, the focus on QOL and well-being outside of a single medical condition context has received much less attention. When considering that physical and mental health represent a traditional dichotomy, one might wonder what impact mental health has on well-being versus other factors.

At the same time, wellness has emerged as a significant industry. The wellness industry, estimated at \$3.7 trillion in 2015, is more than half the \$7 trillion spent on global healthcare and three times larger than the \$1 trillion in global pharmaceutical spending.<sup>2,3</sup> In addition, the wellness industry grew by 10.6% from 2013 to 2015 and is projected to increase by another 5.9% into the year 2020.<sup>4</sup>

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## Mobile Health Tools Could Stretch Critical Resources

by Robert C. Bollinger, M.D., MPH and Sebastian Seiguer, J.D., MBA

**T**here will be a worldwide shortage of 12.9 million healthcare workers by 2035, according the World Health Organization (WHO).<sup>1</sup> Although these deficits will be most acute in Asia and sub-Saharan Africa, the challenges created by too few providers will also be felt domestically. The Association of American Medical Colleges estimates that physician shortfall will be between 61,700 and 94,700 physicians by 2025.<sup>2</sup> High burdens of disease and vast geographical coverage areas exacerbate these shortages.

Two of the WHO's recommendations to address these shortages and better utilize resources stand out as opportunities for innovation. The first recommends using data to assess human resource needs through interoperable health information systems and then using that knowledge to make evidence-informed decisions. The second suggests maximizing the role of mid-level providers and community health workers to make frontline health services more accessible and acceptable.

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## Thought Leaders' Corner

Each month, *Population Health News* asks a panel of industry experts to discuss a topic suggested by a subscriber.

### Q. How Do You Design Population Health Management Tools to Address High-Risk Populations?

The term “population health” represents something of an oxymoron. Merriam Webster defines “population” as “a body of persons or individuals having a quality or characteristic in common.” However, achieving success in managing a population requires careful attention to each individual. Thus, when we consider the design of management tools for population health, we must first specify whether we are focusing on a population or an individual.

While most design specifications for tools to manage population health could be applied to either extreme of the continuum, the translation of those specifications might not be appropriate for both ends.

Here's a quick breakdown of some concepts:

#### Tool Specifications in Common

- User friendly.
- Collects and reconciles data from disparate sources.
- “Just in time” availability.
- Integration with “home” electronic medical records (EMRs).
- Advanced analytics capability.
- Ability to recognize changes with potential clinical significance.
- Multiplatform compatibility.
- “Cloud” based with adequate security for HIPAA compliance.

#### Translation of Specifications for *Individuals*

- Free convenient apps.
- Integrated devices, such as scales, spirometers, glucose monitors.
- Actionable alerts in layperson's language.
- Ability to share information with providers anywhere.
- Basic graphs/reports to show trends.
- Ability to specify a patient “proxy.”
- Ability to serve special populations.

#### Translation of Specifications for *Population Managers*

- Advanced analytics and reporting capabilities.
- “Drill down/roll up” functionality.
- Availability at point of care.
- Integration with “home” EMR.
- Ability to alert care manager/provider about worrisome trends.

In the overall scheme of healthcare-related technology, we still have significant opportunities to fine tune and create the tools needed to manage population health optimally regardless of which end of the continuum you're considering.



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## Thought Leaders' Corner

The first phase in population health management was to create aggregated claims data and analytics to identify care gaps to be closed. With limited time and resources, however, providers have come to realize the need to stratify high-risk populations based on more than just the presence of care gaps. They must also determine where their efforts to close those care gaps will deliver the best outcomes. To do this, they must drill down with analytics into two additional areas.

First, they must determine which gaps on which patients will have the greatest impact on patient health, or "impactability." This score will look at factors, such as the number of care gaps, the severity of those gaps (minor or major, based on evidence) and whether closing them will create an improvement in a patient's health. Understanding a risk score for each patient helps providers determine where to expend their resources. Demographic, psychographic and behavioral data further stratify patients.

The second parameter is "intervenability," or the willingness and ability of patients to engage in their own care. Determining intervenability often requires obtaining outside behavioral data, as well as looking at a patient's history of care. Patients who don't fill prescriptions or are "frequent flyers" in the emergency department are unlikely to change. Knowing that, organizations might want to direct care management resources to patients who are more willing to follow a program.

With these two parameters understood and scored, organizations have the opportunity to improve their patients' health and population efforts.



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The key to effectively managing high-risk populations is set, generically, by establishing a deep competency in the individual identification of everyone in a risk pool. Granular understanding of each individual sets the landmark for the predictive analytics necessary to model existing high-risk populations and gain measurable insights on key geographic, socioeconomic, behavioral and consumer factors that affect the precursory, onset and treatment stages of a chronic or risk population.

Once proper identification is established, the process of engagement, risk mitigation, treatment and social monitoring can effectively proceed with the ultimate goal in mind—positive outcomes. Eighty percent of a person's overall health is derived from behavioral factors. Historically, the healthcare market has not had the means, data or inherent expertise to model these population attributes by simultaneously assessing both clinical and social data. This holistic approach yields enhanced outcomes and overall health.

By leveraging a sophisticated consumer data environment that models patient "personas" based on existing patient population segments, hidden chronic determinants could be revealed by any variant or combination of clinical, social or consumer data variables. The key is access to aggregate data pooled from multitudes of sources.

Once a population persona is established, the ideal solution needs to qualify and quantify risk pools; correlate general wellness and consumer scores; apply clinical overlays based on successful treatment protocols; isolate behavioral determinants that predict risk conditions; and identify key consumer behaviors that either amplify or suppress a risk condition. Once established, predictive data models should be enhanced with social monitoring tools to flag risk behaviors in a monitored population.



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Mari Edlin serves as editor of *Population Health News*. She invites you to submit bylined articles on population health issues and case studies illustrating successes with the model. She can be reached at [MLEdlin@comcast.net](mailto:MLEdlin@comcast.net)

## Thought Leaders' Corner

Healthcare professionals and payers often refer to “high-risk populations” as a catch-all term to mean patients who are at a high risk for cost or health deterioration. It’s an easy trap to fall into, lumping all patients into a risk bucket and attempting to apply a uniform approach to engagement and management.

The reality is that the root cause driving the underlying risk factors are highly variable and in many cases, the approach also should vary significantly. I was trying to explain to a non-healthcare friend what we do at Turn-Key Health. It’s much easier to start with a single question.

I ask if they have lost a loved one after an advanced illness and what that experience was like. Invariably, the answer is yes, and it involves bewildering treatment, expense, suffering and late access to hospice, if any at all. I tell them we help to improve that experience and the quality of remaining life.

This subset of “high-risk” populations, those with life-limiting illnesses, should be engaged and managed very differently (i.e., general population health analogous to a good internist). If you develop a heart condition, your internist is likely going to refer you to a cardiologist. It makes a lot of sense; the internist may know some of the diagnostics and treatments, but doesn’t live and breathe cardiology.

Similarly, a specialized approach and skillset are required to successfully engage individuals facing a life-limiting illness. End-of-life and palliative care is a highly specialized field; you need clinicians who live and breathe it to do it right. We don’t get a second chance.



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### Catching Up With Robert Kahn...continued from back page

**Population Health News:** *What has been the most telling research you have uncovered about child health? How has it enabled you to complete the intersection between poverty and childhood conditions?*

**Robert Kahn:** I think our research has begun to show that if you help families address the social determinants of health—the barriers that get in the way of prioritizing health—we can make a difference in child health outcomes. This doesn’t mean the hospital has to address the social issue, but the hospital can help identify the most effective community assets and agencies and facilitate families’ access.

For example, we have published research findings on our partnerships with our regional food bank, with pharmacies and with Legal Aid. Assisting families in addressing these issues helps to build trust. We are listening better, meeting families where they are, and then that opens up new possibilities for more effective healthcare.

**Population Health News:** *What changes would you like to see in treating and caring for children in our healthcare system?*

**Robert Kahn:** I think we need more seamless integration between healthcare and community organizations. That’s going to require changes in our community relationships, our social work roles and our technology for communicating. That is not likely to happen until goals focused on health equity are set at the institutional level and until reimbursement shifts to incentivize a new way of working.

A second major change is needed in the way we partner with parents. Rather than have us deliver a service to their children, parents need to serve as “experts” in their children’s health, ask them for ideas about healthcare redesign and develop ways to meaningfully engage them in improving care. Every day we see parents who, against all odds, have achieved remarkable outcomes for their kids. But we’re moving too fast to stop, recognize their lived experience and expertise and ask them to help us in achieving that for all kids. We’re starting to do that better here; we had 40 parents and caregivers at our recent Learning Network meeting, but we have a long way to go.

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