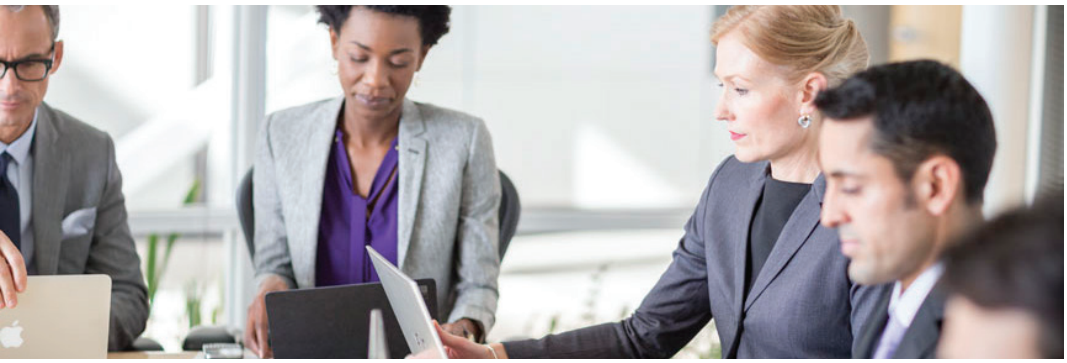
OPTUM®

Building and optimizing a population health management strategy



As payers seek to define their individual approaches to population health management, there is much to consider, ranging from outside influencers to the payer's strategic priorities and membership mix. It's important to understand all the factors to create a successful strategy based on best practices.

Economic pressures and heightened regulatory requirements are shaping the population health conversation. One of the leading influencers is the Affordable Care Act (ACA), which expands access to care and incents organization to take responsibility for improving cost and quality.

Many payers are experiencing a shift in their membership risk profile through ACA and Medicaid expansion, which creates a population that can be challenging to engage. In addition, government innovation and value-based care models are intended to advance performance-based and risk-sharing agreements.

Beyond the evolving regulatory environment, payers' expectations of population health programs are also changing. They're seeking results based on outcomes, as opposed to operational measures. As a result, program optimization is a key priority.

What should a payer focus on, given these influencers?

With the shifting of risk from payers to providers, more payers are focusing on engaging and equipping providers with responsibilities, incentives, tools and resources to take on a broader role in population health management. New population health models have evolved. One example: embedded population health management in the community, which has been shown to provide additional value beyond call campaigns.

However, these programs can be expensive and aren't always cost-effective, depending on the population the plan is trying to reach. In response, IT systems and analytics, and their related processes, have to be sophisticated enough to support these new models so that payers can identify the right people to engage — and engage them optimally.

What to watch

Advancements in bundled payments are lagging in innovation, given the administrative complexities and plans' perceived ability to impact total cost of care through these models. This area is gaining momentum as CMS models proliferate.

So what exactly is population health management?

Establishing a common understanding to enable effective collaboration

Population health management means many things, depending on who is defining it. It's perhaps most useful to compartmentalize its different components based on payer functions and the membership mix that is supported by the population health goals.

Low risk → High risk

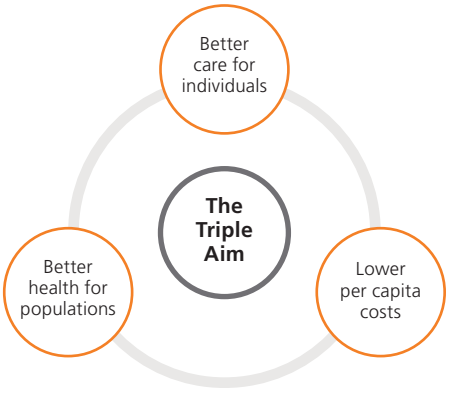
Healthy	Chronic	Catastrophic	Terminal
Health promotion	Disease/case management	Cancer, ESRD, transplant	End of life, advanced cancer
Episodic	Utilization/transition management		
Quality	Quality management		
Coding completeness and accuracy	Risk adjustment		

Consider a health continuum categorized from lowest risk to highest risk: healthy, chronic, catastrophic, terminal. This provides a way to categorize potential cohorts based on inputs such as claims, pharmacy, lab, behavioral assessment and clinical data. Programs can then be developed to address each cohort's needs. For example:

- At the **health promotion** end of the spectrum, the focus is on broad population models encouraging healthy behavior and closing care gaps. As a member case becomes more complex, the programs focus on a broad but tailored set of interventions to promote the right care, the right provider, the right medication and the right lifestyle.
- **Episodic management** takes a different approach to focus programs around utilization management, such as prior authorization, concurrent review and clinical claims review. Goals are typically focused on ensuring that medical events are contractually allowed, performed by preferred providers and evidence-based.
- **Quality management** is a broad category that typically focuses on things like Medicare Advantage quality, Medicaid quality, Stars, HEDIS, accreditation through NCQA and vendor oversight.
- Finally, **coding completeness and accuracy** is important for several reasons — with Medicare Advantage risk adjustment among the top priorities.

Developing the capabilities to support core functions

What do all the programs have in common? Each shares the Triple Aim of: better care for individuals, better health for populations and lower per capita costs. It takes a diverse set of capabilities to achieve the Triple Aim's ambitious goals. In addition, each program needs to be individually robust and optimized. For optimal performance, we believe they also need to be well integrated with one another.



How can these capabilities be optimized?

In the beginning, it can seem like there are more questions than answers in considering the supporting components necessary for promoting a successful population health strategy. As depicted below, the considerations start with strategy and governance and continue through to provider engagement.

Strategy and governance: What investments do we make? Where do we start? What is the value related to developing a new strategy? How are initiatives governed?

ID and stratification
- Where are clinical opportunities?
- How do we identify and stratify our patients into relevant programs?

Core programs/functions
- What clinical and quality programs are needed?
- How should we be organized?
- How do we prioritize work?

Performance management
- What values are my programs delivering
- What providers are performing poorly? Well?
- What processes exist to translate reports into action?
- How do I develop a culture of quality?

Consumer engagement: How do we best engage consumers in managing their health?

Underlying technologies and related functions: What technology do we need to manage our populations?

Provider engagement: How do we transform physician care to become standard, evidence-based and higher quality?

Worth noting: Providers are important stakeholders for achieving success. As the industry transforms from fee-for-service to fee-for-value, there are a lot of expectations put on care teams, so to create a comprehensive strategy, it's important to engage providers to and understand what's important to them.

What does it take to confidently address this complexity?

A comprehensive, value-based approach can work with payers on large and small engagements to help them answer complex questions.

The focus can be on specific areas, such as revamping identification and stratification. Or it can expand across medical management, wellness, quality, risk adjustment and more.

Below is an example the broader, end-to-end approach recommended by Optum®.

Identify goals and assess current state → **Identify opportunities** → **Develop strategic road map**

That is comprehensive ...	... and guided by value
People **Process** **Technology/data and analytics**	• Data driven, leveraging benchmarks where available • Focus on highest value: utilixation, achievable revenue lift, operational efficiency, etc. • Emulate competitor successes and best practices • Look for integration across functions

Why Optum

At every point, the Optum approach is value-driven based on the payer's strategic priorities and membership mix. This best-practice methodology enables payers to confidently evaluate their current state, prioritize solutions and implement a proven population health management plan.

This discipline starts by understanding a payer's population health management goals and assessing the current state. We use that analysis to identify key gaps and opportunities across the payer's people, process and technologies. The results enable us to recommend a strategic road map to achieve the payer's desired objectives.

Learn how Optum can support you in building an overall population health management strategy for your organization.

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