Population Health Management for an Aging Nation

Making Sense of Healthcare Reform

Since the passage of the Affordable Care Act, the term ***Population Health Management*** has been increasingly used by providers, academics, and policy leaders as a key component of healthcare delivery. While there is no one standard definition of the term, it essentially refers to **managing and improving the physical and psychosocial outcomes of select groups of individuals through targeted interventions.**

The purpose of this brief is to better understand population health, keys to success and the unique approaches necessary for an older patient population.

Population Health Management

Population Health Management is a comprehensive approach to addressing the full spectrum of health needs and well-being through cost-effective and evidence-based solutions. It takes into consideration that population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors and environmental factors.

The Population Health Alliance – a global association representing stakeholders from across the entire healthcare delivery system – identifies four key elements of successful population health management:

- **Assessment –** creates an understanding of the patient's health status and needs.
- **Stratification –** separates patient populations into high-risk, low-risk, and the ever-important rising-risk groups.
- **Person-Centered Interventions –** establish a variety of interventions tailored to the unique need of each patient.
- **Impact Evaluation –** measures the impact of interventions to evaluate their effect and to assess the improvement in the health of the population.

Population Health in Action

Accountable Care Organizations (ACOs), Medicare Advantage managed care programs, and care providers rely on a number of Population Health Management strategies to improve quality and better coordinate care for high-risk patients. For example, ACOs have found that electronic health records (EHRs) are critical in order to collect and track data needed to identify and follow high-risk patients. Once these patients are identified, the ACO is better positioned to apply appropriate disease management programs and resources.

Managed Care Organizations, by definition, are responsible for managing the health and outcomes of a defined group of beneficiaries. A 2010 survey published in *Health Affairs* showed that the population health strategies used by Medicare Advantage plans were focused on five categories.

Focus of Medicare Advantage Plans:
Wellness promotion
Focus on patients with multiple chronic conditions
Extra attention for frail older individuals
Reduce hospital admissions
Provide support, education and incentives for outcomes

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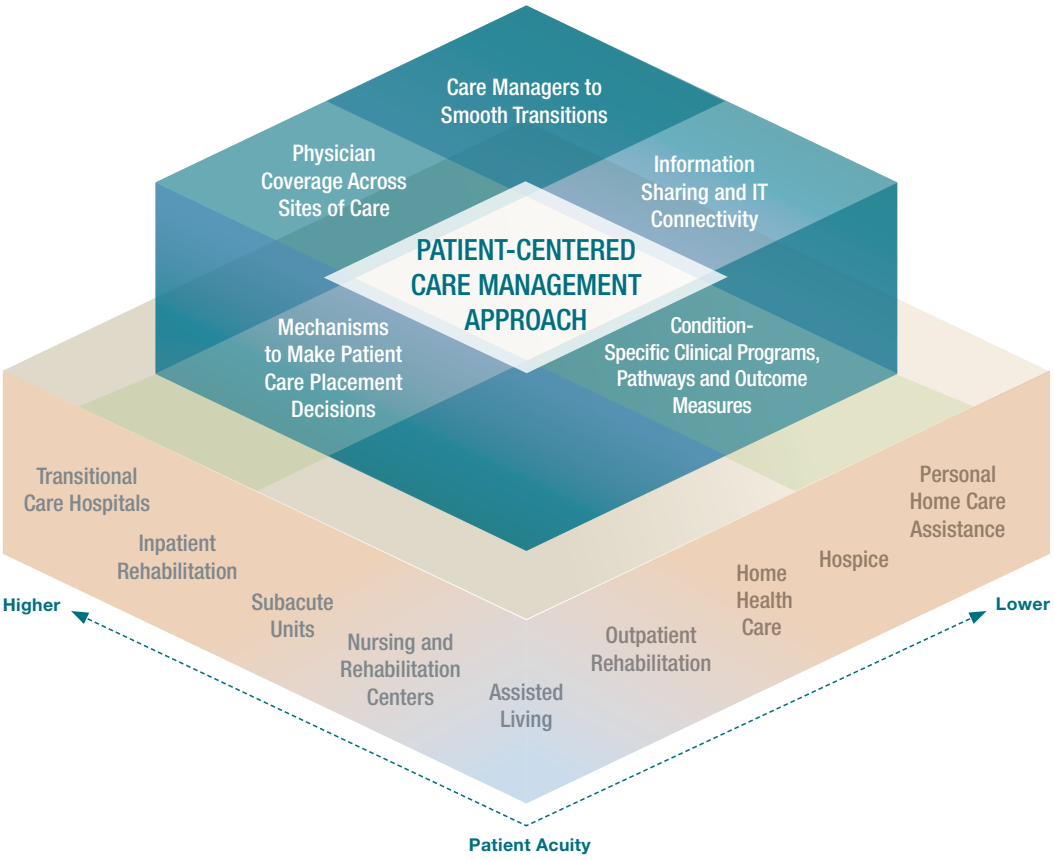
Challenges to Population Health in an Aging Nation

According to the U.S. Center for Disease Control and Prevention (CDC), "more than a quarter of all Americans and two out of every three older Americans have multiple chronic conditions, and treatment for this population accounts for 66% of the country's healthcare budget." These chronic diseases include heart disease, respiratory disorders, stroke, cancer, and diabetes, and they can complicate the health management and treatment for acute illness or injury. Additionally, they negatively impact an older patient's quality of life, and contribute to functional and cognitive decline.

Approaches to a population's health are more complicated than the "single disease" method that is often applied to younger populations.

Individuals who are eligible for both Medicare and Medicaid coverage for their healthcare are commonly referred to as "dual eligibles" by policy makers. According to the U.S. Department of Health and Human Services, this population suffers from significantly higher rates of cognitive impairment, diabetes, hypertension, and heart failure/disease than Medicare-only beneficiaries. This population requires much more in terms of social support services in addition to their health interventions.



Kindred's Experience in Population Health Management

In order to prepare for future payment and delivery systems that link reimbursements to quality outcomes and effective care coordination, Kindred has followed a three-step approach to incorporate population health strategies into its patient-centered care management model.

STEP ONE	Develop the full continuum of post-acute services in local integrated care markets
STEP TWO	Provide care management services to support population health management for patients throughout an entire episode of care – from hospital to home
STEP THREE	Test and implement new models of reimbursement, including "pay for value" and risk-based payment models

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– U.S. Center for Disease Control and Prevention (CDC)

At the bedside, Kindred is taking a three-tiered approach:

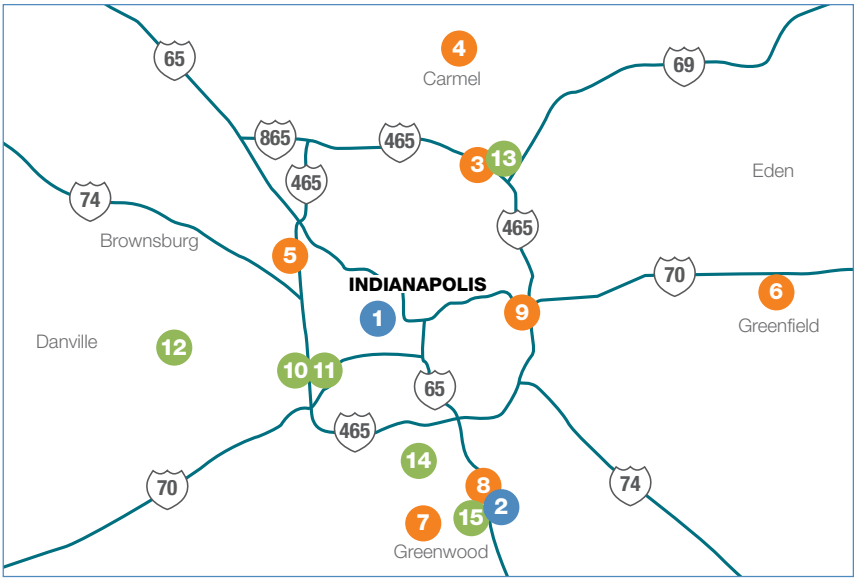
- For the most fragile and vulnerable patients, through the advent of home based primary care teams.
- For the next tier of patients with heart failure, COPD, pneumonia, acute MI and other major risk factors, through our care transitions program, assigning a **Care Transitions Manager** to follow the patient through their episode of care, including into their home, with a 'high touch' approach.
- For the patients who need more active interventions but fall short of the highest tiers, we are developing and implementing a **'Complex Care'** model, where our home health services evaluate and intervene quickly when a patient arrives home, with more intensive services early in his/her episode of care.

Additionally, we have developed and implemented a **Health Information Exchange,** facilitating the seamless transfer of needed information across Kindred settings. Another core component of our care management is the active involvement of restorative therapies, PT, OT and speech, across the continuum.

Through our Care Management program, we partner with hospitals, primary care providers and others to truly 'manage populations' for the best outcomes for our patients. In our Indianapolis market we have placed emphasis on education through our Care Transition Managers, making a significant impact on population health in the patients we care for, as evidenced by our under 10% return to acute rate in 2014 on the highest acuity patients.

KINDRED'S INDIANAPOLIS INTEGRATED CARE MARKET SERVICES

Central Referral Line:
888.566.1234



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For more information, visit **www.kindredindianapolis.com.**

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