How to Prioritize Population Health Interventions
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Sources:


Vanguard Medical Group, Verona, New Jersey.


HIMSS Davies Award, “How the Preventable Admissions Care Team (FACT) Used IT to Expand the Program,” http://bit.ly/1EJ2y0.

Patient prioritization is the key to population health management success.

In an ideal world, all patients—indeed, every person in the population—would have their own personal care managers, who could support them in their health goals and ensure that the health care they receive is coordinated, effective, and efficient.

But care management, no matter how it’s delivered, is expensive. So population health managers need to understand where to deploy their limited care management resources for the best results. And that means they need to be able to establish each patient’s current and future risk level, the root causes of the patient’s health risks, and which interventions would make the biggest impact.

### Three Critical Questions for Population Health Management

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Who are my riskiest patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Which patients over-utilize or under-utilize care?</td>
<td></td>
</tr>
<tr>
<td>• Who will become sick in the future?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Why are they risky?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What social or behavioral risk factors do they face?</td>
<td></td>
</tr>
<tr>
<td>• What is their activation level?</td>
<td></td>
</tr>
</tbody>
</table>

| What is the best intervention for them? |
|• Which care plan will target the root cause of their risk? |
|• Which intervention will be the most impactful for a given patient? |
Even modest prioritization and segmentation efforts can make a difference.

Analyzing an entire population and its risk factors can seem daunting. But health care providers do not require comprehensive data or world-class analytics to begin to make an impact on population health.

When we profiled leading care management organizations around the country, we found that every single one was segmenting its patient population, but they were identifying and managing population risk using tools that were simple as well as complex—sometimes as minimal as a single spreadsheet for common disease states.
A Staged Approach to Advancing Population Health Analytics

- **Achieving Baseline Analytics**
  - Start with clinical data to prioritize patients within key disease states

- **Building the Population Data Set**
  - Use visits and partnerships to capture critical patient data
  - Build in claims data analysis to get holistic population view

- **Attaining Next-Generation Analytics**
  - Incorporate social and behavioral risk factors into segmentation
  - Deploy team to fill remaining data gaps on riskiest patients
  - Prioritize patients by greatest benefit potential

*Read on to learn how* to prioritize your own patient population more effectively.
It’s not enough just to know who your **highest-cost** patients are.

To have any hope of reining in health care spending, health systems need to actively manage care for their highest-cost patients. Thus, pinpointing which patients cost the health system the most is the right starting place for segmenting the patient population. Luckily, high-cost patients are usually comparatively easy to segment, though often difficult to manage.

But engaging in high-cost patient care management alone will not be sufficient for health systems to keep afloat when taking on population health contracts.

When our researchers modeled out the impact of different care management approaches on a capitated contract with 25,000 Medicare patients, they found that if health systems managed only the high-cost patients, they would end up with a nearly 5% negative margin by the fifth year of operation. A positive margin required managing high-cost and moderate-risk patients.
Margin by Risk Management Level*

<table>
<thead>
<tr>
<th>Year</th>
<th>High-Cost and Moderate-Risk Care Management</th>
<th>High-Cost Care Management</th>
<th>Baseline (no care management)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(0.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Patient population segmented between high-cost 5%, moderate-risk 20%, and low-risk 75%.

Model Assumptions for Financial Analysis

<table>
<thead>
<tr>
<th>Metric</th>
<th>Initial</th>
<th>After High-Cost Care Management</th>
<th>After High-Cost and Moderate-Risk Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial cost reduction</td>
<td>0%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Cost growth rate</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Moderate-risk moving to high-cost</td>
<td>18%</td>
<td>18%</td>
<td>12%</td>
</tr>
</tbody>
</table>
Successful population health requires **segmentation** of patients into smaller, more actionable groups.

The reason that managing moderate-risk patients is so important is that today’s moderate-risk and low-risk patients are tomorrow’s high-cost patients—and it can often be more cost effective to try to manage patients before they become “high-cost.” Without intervention, nearly one-fifth of those moderate-risk patients will move into the high-cost category each year.

And yet there are far too many moderate-risk patients in the population for health systems to manage them like high-cost patients. Successful population health managers know not just which patients are at risk, but why they are at risk, and which patients would truly benefit most from intervention. The most advanced organizations are pursuing these analyses at a whole-population level, but targeting high-risk disease states can be valuable in itself.

**VISIT: advisory.com/pophealthplaybook** to explore the key imperatives for building a clinically and financially effective care management system.
Segmenting into Key Patient Groups

- **High-Cost Patients** (5%): e.g., poorly controlled CHF with multiple comorbidities
- **Rising-Risk Patients** (20%): e.g., patient with diabetes and depression
- **At-Risk Patients** (40%): e.g., pre-diabetic patient
- **Healthy Patients** (35%): e.g., patient with no disease diagnosis

**SEARCH: Risk Segmentation** on advisory.com to view our infographic on the key care delivery models needed to succeed under population health.
Use **clinical data** you already have to flag at-risk patients with particular diseases.

Every provider has clinical data in some form, from electronic medical records to laboratory and e-prescribing systems. And while clinical data sets may not have enough information to show a complete picture of health care utilization or risk factors, they can tell you enough to identify patients who could benefit from care management interventions.

Even clinical data contained in a simple disease registry can prove useful. By regularly entering data—even a single laboratory value—and looking for outliers, providers will see just who their riskiest patients are. For example, Montefiore Medical Center in New York has been using its diabetes disease registry to identify patients who are struggling to manage their blood glucose levels and targeting them for intervention.
Diabetes Registry-Based Care Management at Montefiore Medical Center

**Identify Patients**
- Care management organization mines data for increases in HbA1c levels

**Connect to Care Team**
- Nurse reaches out by phone

**Patient is managed telephonically**

**Patient comes in for physician or certified diabetic educator visit**
Mine medical records for telltale signs of undiagnosed risk.

But clinical data doesn’t just provide insight into patients with diagnosed diseases—it can help surface undiagnosed conditions, too.

For instance, since January 2011, NorthShore University HealthSystem in Illinois has flagged over 500 undiagnosed hypertension patients by looking in its EMR system for patients with three blood pressure readings that average higher than 140/90.

Combining several data points can create even more predictive power. Take Minnesota’s HeartBeat Connections program, which aims to prevent heart attacks in people who haven’t yet been diagnosed with cardiovascular disease or diabetes. The program, a partnership between Allina Health and the Minneapolis Heart Institute Foundation, used clinical data from its EMR to calculate risk scores. From this analysis, the program found that one-third of its patients were at risk for future heart disease—and more than half of those were missing at least one recommended preventive medication.
HeartBeat Connections Analytical Approach

EMR Data

**Metabolic Syndrome**
- Blood pressure
- Waist circumference
- HDL2 cholesterol
- Triglycerides
- Fasting blood glucose

**Framingham Risk Score**
- Age
- Gender
- Tobacco use
- Systolic blood pressure
- Total, HDL2 cholesterol

Individuals with ≥15% probability of a cardiovascular event in the next decade
Use **claims data** for a broader view of how patients are using health care—within and beyond your system.

Clinical data sets can give population health managers valuable inputs for prioritizing patient populations by risk level, especially in specific disease states. But looking at clinical data alone means you are missing a great deal of the big picture—especially about utilization that happens outside of your network.

This is where utilization data comes into play, and the most comprehensive form of utilization data that health care providers can access is insurance claims. Insurers typically share these claims with health care providers that are in risk-based contracts, though the claims often are delayed several months before they become available.

**Clinical Data Provides Accuracy in Detail**

**Strengths:**
- Close to real-time availability
- Rich clinical detail not available in claims

**Weaknesses:**
- May reside in multiple EMRs and other systems; integration required
- Most useful when limited to a specific disease state (e.g., diabetes, CHF, COPD)

**Claims Data Enables Broad View**

**Strengths:**
- Spans care delivery settings
- Provides out-of-system view of patient utilization

**Weaknesses:**
- Difficult to attain without signing risk-based contract
- Delayed availability (months)
- Limited granularity on clinical condition
- Out-of-pocket expenses not captured
Simply looking at past utilization can reveal opportunities to intervene—sometimes obvious, sometimes more subtle.

For example, Capital District Physician’s Health Plan in Albany, New York, wanted to develop a community outreach strategy for its Medicaid population. But, since it couldn’t target every single Medicaid beneficiary, it looked at claims data and identified three groups likely to need additional support. It started with over-utilizers, but also targeted patients who were currently non-utilizers (with zero claims in the current year) and under-utilizers (with past diagnoses but no care in the past year) because those latter two groups had previously been shown to be at risk for high costs and poor outcomes in the future.
With risk-scoring algorithms, past claims data can predict the future.

While examining utilization patterns directly can be helpful, more advanced population health managers are using quantitative risk scoring approaches to identify which patients to target more rigorously and comprehensively. There are dozens of methodologies for risk scoring, but they usually incorporate demographic data as well as medical claims and pharmacy claims.

Claims-Based Risk Scoring Inputs

Demographic Data
- Provides baseline estimate of expected cost and utilization risk
- Includes:
  - Age
  - Gender
  - Zip code
  - Plan type

Medical Claims
- Allows for analysis of diagnoses and utilization patterns
- Includes:
  - Diagnosis and procedure codes
  - Site of care
  - Date of service

Pharmacy Claims
- Refines medical risk; fill rate serves as proxy for activation
- Includes:
  - Date of prescription
  - Drug code
  - Quantity

Predictive Value of Risk Score
One example of this approach in practice comes from Memorial Hermann Physician Network in Texas, which used The Advisory Board Company’s Crimson Population Risk Management system to segment patients and manage care for patients under risk.

As the health system has begun to take on risk-based contracts, it is requesting claims data from payers and feeding that data into the Crimson system to risk-stratify across all patients within its risk-based contracts. With the help of Crimson, Memorial Hermann can now quickly and accurately target its care management resources to the right patients, achieving a savings of $307 per patient, per year.

SEARCH: Risk Segmentation on advisory.com and subscribe to the Care Transformation Center Blog for ongoing research about the usage of clinical and claims analytics to prioritize care transformation.
Clinical and claims data sets still have gaps, especially for disengaged patients.

Even with a profusion of clinical and claims data, population health managers will still be missing important information about at-risk patients.

For one thing, providers will not have clinical information on patients who are entirely disengaged from the health system. To capture data on people who don’t interact with the health system frequently, providers can connect with groups that are in contact with these individuals. In Washington, DC, MedStar Health has set up screening programs in barbershops to reach men who might be at risk of heart disease. The screening partnership not only uncovered undiagnosed hypertension and high blood sugar but also was able to connect the men with treatment.

### MedStar Health “Hair, Heart, and Health” Program Results

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td>Previously undiagnosed participants with hypertensive or pre-hypertensive BP readings</td>
</tr>
<tr>
<td>19%</td>
<td>Participants with uncontrolled BP referred to and tracked for follow-up care</td>
</tr>
<tr>
<td>9%</td>
<td>Previously undiagnosed participants with elevated blood sugar</td>
</tr>
</tbody>
</table>
Another example of how providers can go outside their own walls to gather data is Duke University Medical System’s effort to target patients with a risk of lead poisoning. Duke used census data, county tax filings, and public health records to map out exposure risk by household. From there, it could pinpoint exactly which neighborhoods had residents with the highest risk for lead exposure. Through this data-gathering exercise, Duke improved its success rate in identifying at-risk families by sixfold—and did so without incurring any additional costs.

Even when providers know who the at-risk patients are, the lag time before claims data flows back to providers means that they could miss important changes in health status that could require intervention. Mount Sinai Medical Center in New York City closes this gap by having its nurses ask all patients whether they’ve been to any hospital recently as part of routine intake.

Creating real-time clinical data feeds can be a useful, but also costly and labor-intensive, way to get more timely signals of patient needs. These data feeds can involve remote monitoring technology, such as wireless heart monitors or GPS-enabled asthma inhalers.

In one example we came across, a targeted group of diabetes patients—those in rural areas with at least one ED visit or hospitalization in the past year—call in to a phone line set up by the Iowa Chronic Care Consortium to report their daily symptoms to a nurse care manager, who can determine which patients need follow-up intervention.
Uncovering the reasons behind patient risk lets you intervene more effectively.

For many patients, understanding their clinical risks doesn’t provide enough information to inflect their risk profile; population health managers also need to understand the broader factors that are driving those risks. And that means looking at factors not typically considered “medical”: do some patients live in an unstable housing environment? Or do they lack the transportation they need to see their primary care physician?

Understanding the root causes of risks gives care managers a much better idea of which interventions will actually make a difference. But that means that population health managers should consider a broader set of risks, including social risk, geographic risk, and behavioral risk. In addition, the degree of patient “activation”—health literacy and engagement—can make a big difference in which interventions are most appropriate and most effective.
### Summary of Non-clinical Risk Factor Data Inputs

<table>
<thead>
<tr>
<th>Risk Type</th>
<th>Data Elements</th>
<th>Advantage Gained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Risk</td>
<td>• Age, gender&lt;br&gt;• Level of social support&lt;br&gt;• Home environment&lt;br&gt;• Social relationships</td>
<td>Allows clinician to identify wraparound support services for individual patient</td>
</tr>
<tr>
<td>Geographic Risk</td>
<td>• Average income&lt;br&gt;• Housing value&lt;br&gt;• Distance from health care services</td>
<td>Quantifies community-level risk factors; prioritizes patients and community-level interventions</td>
</tr>
<tr>
<td>Behavioral Risk</td>
<td>• Anxiety&lt;br&gt;• Depression&lt;br&gt;• Stress&lt;br&gt;• Mental health symptoms</td>
<td>Allows clinician to prioritize behavioral health interventions</td>
</tr>
<tr>
<td>Patient Activation</td>
<td>• Health understanding&lt;br&gt;• Health literacy&lt;br&gt;• Engagement&lt;br&gt;• Confidence</td>
<td>Provides guidance on intensity and approach to behavior change management</td>
</tr>
</tbody>
</table>
Map patient interventions to root causes of risk.

For example, three hypothetical male diabetics in their sixties could require substantially different interventions, depending upon their non-medical risk factors. If one of those patients had no other psychosocial risk factors, he might not be considered risky enough to need any immediate intervention. Another patient, with limited home support and poor health literacy, could benefit from geriatrician home visits. And a third patient with the same medical profile should be referred to behavioral health support if he has identified psychological issues.

Unfortunately, collecting information on psychosocial risk can be time- and resource-intensive. To keep the process more manageable, focus in on patients who already have known medical risks—and make the most of existing sources of data.
Example of Targeting Interventions by Risk Factors

Three 61-year-old, male diabetic patients

1. Principal diagnosis of diabetes
   - Prior hospitalization
   - Not high-risk

2. Principal diagnosis of diabetes
   - Prior hospitalization
   - Poor health literacy
   - No patient support
   - High-risk due to social frailty
   - Sample intervention: geriatrician/NP home visits

3. Principal diagnosis of diabetes
   - Problem medications
   - Polypharmacy
   - Psychological issues
   - High-risk due to behavioral health issues
   - Sample intervention: referral to behavioral health
Understanding and mapping patient activation will be key to providing the right care management.

Stanford Hospital & Clinics in California has incorporated patient activation into its patient stratification and care planning. Stanford categorizes patients along two dimensions. The first assesses along four domains of risk, such as a patient’s social isolation or their ability to self-manage care, which help uncover the root cause of the patient’s risk. The second dimension of risk, patient activation, further refines patient care management.

Stanford measures patient activation using the Patient Activation Measure (PAM) score. The PAM score is a set of questions that measures patients’ health care knowledge, skills, and confidence in managing their own health. Stanford then determines the best management approach based on both the patient’s risk driver and their level of activation. For example, a medically complex but highly activated patient may not require intensive coaching. For this patient type, Stanford focuses on coordinating care between primary care, care managers, and specialists.
Matrix Used to Tailor Management Approach

**High**
- Coordinate care among specialists
- Call frequently, connect to community resources
- Provide transportation, increase trust

**Low**
- Make it about their goals, not ours

**Domain**

**Lack of Access**
- Access to care
- Experience with providers
- Coordination of care

**Social Isolation**
- Home environment
- Job and leisure
- Social support
- Social relationships

**Medical Complexity Only**
- Chronicity of medical condition
- Symptom severity
- Diagnostic challenges

**Failed Self-Management**
- Engagement
- Resistance to treatment
- Mental health symptoms

**Patient Activation Measure Score**

- High
- Low
To further understand non-clinical drivers of risk, consider seeking out data from external organizations.

Even though population health management organizations themselves may not have psychosocial risk data at their fingertips, other organizations likely already have crucial pieces of the puzzle.

For instance, tap into clinical partners such as visiting nurse services that conduct in-home assessments and collect information on home environment and other aspects. Such groups often share considerable information with partner hospitals.

Community organizations can be another source of risk information; compare your patient list with a group’s client roster to find out which organization might have the most data on your patient population. Partnerships with technology vendors and data aggregators—especially those that collect consumer data—also can be fruitful.
Potential Sources of Psychosocial Data on Patient Risk Factors

**Clinical Partners**
PACs, independent physicians, and payers may already be conducting psychosocial and behavioral assessments.

**Community Organizations**
Organizations that provide social and economic support have existing databases of at-risk individuals and may have additional data on individuals’ needs.

**Technology Vendors**
Digital health companies collecting data on patient health indicators and behavior; data may either be input by the user or passively collected.

**Data Aggregators**
Retailers, credit score companies, and market research firms have access to large demographic and psychographic data sets.
Collect more root cause data through your own targeted initiatives.

Providers can consider a variety of effective ways to amass additional risk details. However, since additional data collection is often a drain on limited resources, providers must carefully target their efforts here.

Targeting patients in waiting rooms is one relatively simple way to get started. Patients waiting for appointments can complete a quick survey of social and behavioral risk factors—such as one by the start-up Healthify—using either an iPad or computer. Once complete, the Healthify survey tool alerts the care team of any possible issues that may affect a patient’s overall health, such as risk of depression, to probe further.

Another strategy worth mentioning is hospital-based in-person data collection. Mount Sinai Medical Center’s work to understand which of its patients are most likely to be readmitted is an example of this in practice. The hospital uses information from its EMR to identify which patients have the highest risk of readmission. Providers then go directly to those patients’ bedsides to administer a 60-minute psychosocial assessment. The effort has paid off; Mount Sinai has reduced its 30-day readmission rate by 50%.

At a more basic level, telephone outreach can be similarly illuminating. Consider OSF Medical Group, in Illinois, which relies on Milliman risk scores to select patients who will receive a phone call from a non-clinical staff member. After assessing the patient via the phone, the staffer is able to decide whether the patient requires additional care management.
### Assessment of Psychosocial Data Collection Opportunities

<table>
<thead>
<tr>
<th>Physician Office</th>
<th>Hospital</th>
<th>Telephonic Outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td>Access to lower-risk population</td>
<td>Long visits and multitude of staff present ample opportunity for data collection</td>
</tr>
<tr>
<td><strong>Challenges</strong></td>
<td>May lack staff or time to collect data</td>
<td>Likely limited to highest-risk patients; resulting interventions largely reactive in nature</td>
</tr>
</tbody>
</table>
| **Data Points to Prioritize** | • Behavioral health risk factors  
• Patient activation | • Out-of-system utilization  
• Psychosocial factors driving readmission | • Psychosocial barriers to care  
• Patient activation |
| **Target Population** | • All populations | • High-risk  
• Rising-risk | • High-risk  
• Rising-risk |
For the best return on population health efforts, prioritize interventions based on expected benefit, not patient risk.

Once population managers analyze not just medical but also social and behavioral data on patients, they can create a list of potential interventions for each patient, prioritized not just on the patient’s overall risk level but on which interventions are most likely to make in impact.

This can be a manual effort, where clinicians review a candidate list of potential high-risk patients that has been generated by algorithm. However, we have also seen a few organizations using analytical approaches to calculate “benefit scores” to prioritize interventions. For instance, Colorado Beacon Consortium, based in Grand Junction is using the Archimedes IndiGO® analytics system to create benefit scores for patients, based on individual data and literature-based assessments.
### Sample IndiGO® Patient Ranking Output

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Risk of Diabetes (%)</th>
<th>Risk of Heart Attack/Stroke (%)</th>
<th>Benefit Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>4215</td>
<td>Cindy Klein</td>
<td>49</td>
<td>F</td>
<td>14.7</td>
<td>8.8</td>
<td>27.1</td>
</tr>
<tr>
<td>4255</td>
<td>Gary Saunders</td>
<td>62</td>
<td>M</td>
<td>12.5</td>
<td>7.2</td>
<td>26.5</td>
</tr>
<tr>
<td>4424</td>
<td>Maxine Collier</td>
<td>57</td>
<td>F</td>
<td>9.8</td>
<td>2.2</td>
<td>26.3</td>
</tr>
<tr>
<td>3453</td>
<td>John Hines</td>
<td>44</td>
<td>M</td>
<td>5.5</td>
<td>2.9</td>
<td>25.4</td>
</tr>
<tr>
<td>7542</td>
<td>Dora Tran</td>
<td>46</td>
<td>F</td>
<td>2.9</td>
<td>2.9</td>
<td>22.9</td>
</tr>
<tr>
<td>5445</td>
<td>Joy Sparks</td>
<td>59</td>
<td>F</td>
<td>8.5</td>
<td>7.0</td>
<td>20.5</td>
</tr>
<tr>
<td>3125</td>
<td>James Coleman</td>
<td>37</td>
<td>M</td>
<td>0.8</td>
<td>18.5</td>
<td></td>
</tr>
<tr>
<td>7887</td>
<td>Elizabeth Jones</td>
<td>57</td>
<td>F</td>
<td>5.9</td>
<td>14.3</td>
<td></td>
</tr>
<tr>
<td>3125</td>
<td>Ron Graham</td>
<td>32</td>
<td>M</td>
<td>2.5</td>
<td>0.5</td>
<td>10.9</td>
</tr>
<tr>
<td>7780</td>
<td>Ed Roy</td>
<td>23</td>
<td>M</td>
<td>0.2</td>
<td>8.7</td>
<td></td>
</tr>
</tbody>
</table>

Care team focus based on benefit score
Population analytics represent a necessary **first step** toward care transformation.

Population health managers can have the best data and the most powerful analytic systems, but in the end, they are only as effective as their ability to intervene to improve patient outcomes. Perhaps unsurprisingly, when we surveyed health care leaders in the summer of 2013, we found that many more believed they had access to robust information than thought they had the right analytics or the care management infrastructure to intervene.

The good news—we have a wealth of resources to help you with the population health transformation.

Visit us at advisory.com/caretransformationcenter for the latest insights, best practices, and tools for population health management success.

To browse all our research on population health, visit our population health resource page at advisory.com/topics/pophealth

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Additional Resources

Primer on Avoidable Costs
Understanding opportunities to inflect avoidable costs is the first step to population management. Learn to identify and prioritize opportunities to reduce the total cost of care.
advisory.com/avoidablecosts

Playbook for Population Health
For aspiring population health managers, clinical and financial success depends on successful leadership and care model transformation. This study provides a comprehensive blueprint for that transformation.
advisory.com/pophealthplaybook

High-Risk Patient Care Management
Learn to identify and manage high-risk, high-cost patients using targeted care management tactics that prioritize a comprehensive care approach and patient activation.
advisory.com/highriskcaremgmt
About the Care Transformation Center
This piece is based on a larger research initiative on care transformation. We provide expert guidance to our members as they manage the transition to large, integrated systems responsible for managing patients’ health across the entire care continuum.

To learn more and access additional resources, visit advisory.com/caretransformationcenter

More Support on Care Transformation

Crimson Population Risk Management
Performance technology initiative that helps hospitals manage total cost and quality for defined populations—including self-insured employee plans—and inform risk-based contract negotiations with payers. advisory.com/crimson

Population Health Advisor
Cohort-driven collaborative supporting the chief transformation officer combining in-person peer summits with ongoing, in-depth research and customized guidance. advisory.com/populationhealthadvisor

Southwind
Helps hospitals and health systems achieve full medical staff integration through physician practice management and consulting services addressing physician employment, physician practice acquisition, clinical integration, and alternative models of physician alignment. advisory.com/southwind
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Tom Liu

Practice Manager
Megan Clark

Project Editors
Michael Koppenheffer
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Designer
Kate Young

Sources:


Vanguard Medical Group, Verona, New Jersey.


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