Important Content Note:

This technical assistance resource was developed prior to the August 2017 release of the Health Center Compliance Manual by the Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care (BPHC). The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

Because of increased funding and an accompanying increase in expectations, health centers are justifiably concerned when it comes to new trends and buzzwords. They often view a new initiative or program as one more task for an already overburdened workforce and another reason for patients to be dissatisfied. The result is a narrow focus on satisfying requirements with the minimum disruption and cost rather than the most effective way to accomplish the program goals. Population health, however, is not a new trend or buzzword but rather a framework that positions a health center to be successful in the work they are already doing. When viewed through that lens, population health and its core competencies can open up a health center to greater success.

Health centers across the country have had the opportunity to work with Shannon Nielson, Senior Vice President of Consulting Services at Centerprise, Inc., implementing population health strategies. There are many key lessons to learn from Shannon’s work and she was willing to share some of them with us. Shannon described the following top six areas she focuses on when working with health centers and how they work together to improve patient care, workflow design and quality of care.

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## The Primary Health Center Obstacle When Implementing Population Health

A common misconception is that population health is simply the process of becoming a Patient Centered Medical Home (PCMH). In fact, according to Shannon, a health center’s primary challenge in implementing population health initiatives is understanding what population health is beyond the c-suite. Shannon defined population health as a focus on the health outcomes of a group of individuals. In order to have a successful population health program, health centers need to understand how it plays into the strategic vision, connects with ongoing initiatives, and impacts the day-to-day operations. A great way to clear this misconception is to create a value-based statement, which walks through relevant definitions and the impact of interventions regarding the triple aim. Different than a simple mission statement, the value-based statement reflects the overall work breakdown for the practice and how each component positively impacts others.

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### Successful Practices in Accountable Care: Centerprise, Inc.

#### Company Profile

- **Company Name**: Centerprise, Inc.
- **Founded**: 2014
- **Location**: Milford, Ohio
- **Consulting Services Offered**: population health strategies, revenue cycle management, insurance billing, professional and consulting services

- **Shannon Nielson**: Shannon serves as Vice President of Consulting Services and leads Centerprise’s consulting arm, working with practices, hospitals, and large organizations in value based transformation and revenue cycle management. She has extensive experience leading organizations through practice transformation processes including Patient Center Medical Home (PCMH), Meaningful Use and EHR, Comprehensive Care Initiatives and Accountable Care Organizations.
In her experience, Shannon has found health centers are more successful when they consider the intent of the requirements they are trying to meet as well as how they fit within the value the health center is trying to provide. By assessing the intent behind the requirements, a health center can understand how population health models operate, successfully project their information technology needs, drive patient centered access, maximize care coordination efforts, implement team based care, and see an improvement in both quality and performance measures.

Shannon Recommends: Instead of this being a c-suite only process, have the entire health center’s staff work together to draft a value statement to guide their decisions and actions.

Information Technology (IT) Needs

Essential to a population health initiative is the technology infrastructure to understand the current patients a health center sees, the larger population in the community as well as patients assigned via a managed care. Health centers must begin with an optimized Electronic Medical Records (EMR) based on efficient workflows, standardized documentation, and validated data. The ability to identify high-risk, high-cost patients requires refined and accurate data systems capable of targeting these specific patient populations. After an optimized EMR is in place, health centers need to have a data analytics solution that is visually appealing and user-friendly for patient engagement and front-line provider use.

With an optimized EMR and a data analytics tool in place, health centers should consider a strong data aggregation tool that can interface with multiple EMRs to better understand the patients not currently visiting the health center. Shannon also recommends investment in a robust quality improvement/data analytics team to pull together the data, financial and operational aspects of the initiative. Shannon has found that connectivity and integration are at the heart of the IT needs for a population health program.

Shannon Recommends: Consider the patient portal as a part of a high functioning care team and utilize it accordingly.

Patient Centered Access

Patient Centered Access is a core competency for population health. According to Shannon, there is a wide range of ways to approach access, but it boils down to one basic premise: get in the mind of your patients. One practice Centerprise encourages is to survey patients outside of the traditional patient satisfaction survey to get the patient’s perspectives on their own behavior. For instance: What does ‘access’ mean to health center patients? Why do patients use or not use the portal? What are deciding factors in their visitation schedule? This simple survey allows a health center to understand the patient’s perspective around access and involves the population in defining what access means for them. Shannon mentions one practice which has a quarterly open house for new patients to meet all members of the care team over punch and cookies. Patients take advantage of the opportunity to learn about the care team, portal and tour the facility. This sort of activity increases access and team based care concepts.

The other tool she recommends using is a manually created “third next available” report. A third next available report measures the average length of time between the day a patient makes a request for a specific type of appointment and the third available appointment open for the specific type requested. This report more accurately reflects appointment availability due to cancellations. By more accurately measuring the demand of patients, and understanding that demand, health center can position themselves to successfully deliver patient care. Patient centered access drives many of the other interventions.
which have proven essential for population health such as care coordination.

Shannon Recommends: Utilize surveys and a “third next available” report to better understand patients’ desire for access.

Care Coordination

No other intervention has the ability to hit all the goals of the triple aim (improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care) as care coordination, and it is an essential part of population health. Quite simply, patient behavior outside the “four walls” of the health center is just as important as the care received inside it. It is care coordination that provides patients with the continuous, longitudinal support between physical encounters. Care coordination is the connector between all of the providers and services patients use to improve their health. A proper care coordination program reduces emergency room visits, improves patient’s medication compliance, and ensures better clinical outcomes. This leads to improved patient and provider experiences as well.

Some challenges that health centers face in establishing a care coordination program are the costs and IT needs. Often care coordinators do not have a structured way to document and import information into and integrated a patient’s record. They also do not have easy access to information outside of the health center. In order to overcome these challenges, Shannon recommends forming relationships with community providers and exploring other partnerships. The skills gained in forming relationships outside of the health center are easily transferable to the work necessary inside the health center to provide team based care.

Shannon Recommends: Hire care coordinators willing to serve as partners for the patients and the providers.

Team Based Care and Transparency

Population health strategies require a shift in mindset for care providers, so involving all health center staff in the initiative is very important. All members of a health center’s staff need to be involved from the planning process through implementation and review to foster a collaborative approach. In fact, one of the greatest opportunities, Shannon explained, is when a practice has staff who do not understand on the changes and were not included in the process. To involve all staff, the executive team needs to be transparent in sharing baseline data and provide regular updates. In sharing data, staff can understand both areas for improvement and the fruits of their labors, ushering in the capability for greater change.

This is true of financial pieces as well; these are not separate conversations in value based or population health models and should not be treated as such. Clinical teams usually have no idea how much money their performance impacts revenue or how much money health centers may forego as a result. Aligning the financial and value-based aspects of the system can only happen through transparency. Shannon recommended taking a similar approach for staff engagement as used for patient engagement, such as motivational interviewing. In doing so, a health center can utilize skills they have already learned to affirm that the process will deliver the outcomes and build trust.

Shannon Recommends: Focus on building a team that is integrated and flexible in their approach.
Quality Improvement and Performance Measurements

Population health programs are long-term efforts. Properly implemented plans may see improved patient retention rates within the first six months. However, clinical measures may take a longer time to quantify depending on their relevant population. While an improvement may be sustainable after six months, it will take eighteen to twenty-four months to be consistent and reliable. The best way to observe these changes is to benchmark against yourself (past years’ UDS data), similar organizations, and other health centers in your state.

By focusing on population health, a health center can learn key skills essential to many accountable care platforms. Understanding IT needs, providing patient centered access, coordinating care, providing team based care, and focusing on quality improvements are competencies necessary to achieve the triple aim and transferable in a rapidly changing care delivery system.

Shannon Recommends: Remember that clinical data is seasonal and change takes time.