Population Health: A New Paradigm for Medicine

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ABSTRACT

Healthcare delivery system reform has become a dominant topic of conversation throughout the United States. Driven in part by ever-higher national expenditures on health, an increasing number of payers and provider organizations are working to reduce the costs and improve the quality of healthcare. In this article, we demystify the term "Population Health," review some of the larger payer initiatives currently in effect and discuss specific provider group efforts to improve the quality and cost of healthcare for patients.

Key Indexing Terms: Population health; Healthcare reform; Payment reform. **[Am J Med Sci 2016;351(1):26–32.]**

HISTORIC EVOLUTION OF "POPULATION HEALTH" CONCEPTS

Since the early 1900s, the fields of medicine and public health have been diverging. As medical technology has advanced, the medical care delivery system has focused more on the treatment of acute illness and management of chronic disease in individual patients. All medical students are taught to respect the sanctity of the doctor-patient relationship and are rarely ever asked to consider the effect of their management decisions on a population bigger than the individual in front of them at the time. The fee-for-service financing structure of American healthcare reinforces this individual transaction perspective.

Public health, on the contrary, has maintained its focus on the health of populations, usually defined by geography. This geographic focus is due largely to the government financing structure in place to fund public health activities at the state and county levels. Furthermore, public health remains the group most concerned with factors affecting health other than medical care access. Clean air and water, infectious disease control and other social and environmental health determinants are key aspects of public health.

The use of the term "population health" increased in the published literature between 1989 and 1994. By 2000, articles using "population health" as a keyword were published at a rate greater than those describing "public health" or "health promotion."[1] Interestingly, the definition of population health was still being debated in the literature[2] at the time this increase in publication frequency was occurring. Kindig and Stoddart published one of the most widely cited definitions in 2003:

> *The health outcomes of a group of individuals, including the distribution of outcomes within the group*.[3]

This definition has particular strength in that it can be embraced by both the public health sphere and medical care delivery system. It requires considering determinants of health such as social and environmental factors as well as care delivery issues including access to care and care quality. This definition does not place responsibility for improving population health on the shoulders of either public health or the medical care delivery system, but should require both to work together for real progress to be made.

A catalyst driving the growing interest in population health is often cited to be the Patient Protection and Affordable Care Act (aka: Affordable Care Act [ACA], "Obamacare").[4] In addition to increasing the population covered by health insurance, the ACA gives Medicare the ability to experiment with payment mechanisms to incentivize the medical care delivery system to pay greater attention to costs, clinical outcomes as well as disease prevention and wellness; the Pioneer and Shared Savings Accountable Care Organizations are examples of this new authority in action. Medicare's experimentation has had a spillover effect into the commercial insurance market, leading to a significant increase in private insurers embarking on similar experiments.[5] This creates an incentive for the medical delivery system to work with the public health system to try and prevent avoidable clinic visits, emergency department visits and hospital admissions through strategies focused on illness prevention.

Although the debate about a precise definition of population health may continue,[6] payers and providers must begin to collaborate to maximize the value of future healthcare spending.

PAYER-BASED POPULATION HEALTH ACTIVITIES

The fee-for-service reimbursement system used throughout the United States is often touted as a direct

contributor to the high cost of healthcare in this country. By paying doctors and hospitals to do "things," more "things" may be done whether they are needed or not. Payment reform experiments are not novel. Kaiser-Permanente's prepaid medical model began in the 1930s, concepts like capitation contracting started infiltrating the Center for Medicare and Medicaid Services (CMS) as early as the 1970s with limited success.[7,8] The novelty in the current healthcare reimbursement reform landscape is the inclusion of attempts to measure and reward care quality in many of the more advanced payment reform initiatives underway.

In January 2015, CMS further reinforced its intention to move aggressively to value-based reimbursement methodologies by 2018 when it stated that 90% of Medicare payments would be linked to quality and 50% through an alternative payment model.[15] To facilitate this transition, CMS is also creating "Learning Action Networks," which brings together HHS, private payers, large employers, providers, consumers and state and federal partners to share best practices, develop new payment models, define attribution methodologies and other tasks necessary to transition away from fee-for-service-based reimbursement.

Federal Programs

The Center for Medicare and Medicaid Innovation has been hard at work since its inception creating numerous payment experiments meant to improve the cost and quality of medical care for Medicare beneficiaries; at the last count there were more than 50 experiments in process or recently completed.[9] These new models have had a broad range of scope.[10]

The Accountable Care Organization (ACO) initiatives, both Pioneer and Medicare Shared Savings Program, are single-payer initiatives but encourage medical care delivery organizations to collaborate in ways not previously allowed due to antitrust regulations. In some cases this has led to traditionally competitive physician groups, hospitals and health systems joining together to create an ACO and collaborating to provide the highest quality care possible to their shared patient populations. It has also led to collaborations of medical care provider organizations at various points along the continuum of care. Although these experiments are still in early stages, and their financial returns for provider organizations have been mixed, there has been a demonstrable improvement in the quality of care delivered to Medicare beneficiaries and significant savings for the Medicare Trust Fund.[11,12]

The Multipayer Advanced Primary Care Practice Demonstration is ongoing in 5 states. This experiment leverages the influence CMS can exert on commercial payers and attempts to transform the way primary care practices deliver care. Specifically, each participating payer makes monthly per-member payments to participating providers. These funds are meant to cover care coordination, improved access, patient education and other services to support patients with chronic illness.[13] Results from this demonstration are not yet available; however, CMS has renewed the demonstration in 5 of the original 8 states owing to promising initial results.[14]

These 2 specific CMS experiments are emblematic of the rest of the innovation portfolio. This focus on multipayer and multiprovider organization collaboratives is all in service to the overarching goal of reducing cost and improving the quality of medical care provided to Medicare beneficiaries.

Commercial Payers

Blue Cross Blue Shield (BCBS) of Michigan (BCBSM) embarked on a payment reform initiative in 2004, The Physician Group Incentive Program (PGIP), which was intended to improve the cost and quality of care provided to BCBSM beneficiaries. It initially focused on improving chronic disease management and then expanded to implementation of Patient-Centered Medical Homes (PCMHs). Through PGIP, participating providers can earn an incentive payment by implementing specific PCMH capabilities, accepting accountability for certain quality measures and achieving specified use and quality benchmarks.[16] Participating providers receive regular reports from BCBS describing their performance, so they can measure the effect their improvement efforts have on their performance. Organizations have complete autonomy to spend the incentive dollars in the manner that they believe would most effectively meet their goals for participation in the program.[16]

Initial data showed that the PGIP program had the intended effect on both the quality of care and payer-associated costs, and the degree of PCMH implementation correlated with the amount of improvement in quality and cost.[17] Newer data show the PGIP program generated sufficient savings to offset program costs while maintaining or improving quality scores for adult and pediatric patients served by enrolled providers[18] while also decreasing disparities in cancer screening across socioeconomic groups.[19]

Building on the success of the primary care components of PGIP, BCBSM has expanded the program to more than 35 specialties. The goal of this program is to expand the concept of the "Patient-Centered Medical Home" to a "PCMH Neighborhood" through which specialists actively interact with and coordinate care of their shared patients with primary care providers. Specialists are eligible to receive an increased professional fee, called an "uplift," if they meet cost, quality, use and efficiency metrics. In 2014, more than 5,000 specialists received an uplift. An interesting aspect of this program is that it is often based on "population-level" performance versus "practice-level" performance. For example, pediatric pulmonologists would be judged on the rate of

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