Moving Towards Population Health Management
What You Need to Know

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What is Population Management?

Those working in the field of public health are more accustomed than psychologists to hearing the term 'Population Management.' In that context, the term refers to treatment and prevention strategies for groups of individuals defined by geographic location, demographic variable, or diagnosis. The U.S. Agency for Healthcare Research and Quality (AHRQ) recently coined the term "practice-based population health" (PBPH), in which the term 'population' refers to any group of people under the care of single physician, group practice, PCMH or ACO (Cusack et al, 2004).

Primary healthcare is increasingly moving in the direction of a PBPH model, which assumes that medical providers are responsible for increasing the *overall health of the population* they manage, and not just for treating individual patients who present in their office for care. This shift is driven primarily by financial changes in healthcare reform, explained further below. However, the adoption of a PBPH model is also determined by, and further encourages, structural and cultural changes in primary care.

FINANCIAL: Healthcare reform now encourages public and private insurance companies to give up a traditional volume-based reimbursement (pay per visit) system in favor of outcome-based reimbursement (pay based on health improvement). The former system pays doctors for each service provided and is thought to lead to an increased volume of services, without necessarily improving health. The latter system is thought to encourage providers to focus more heavily on prevention efforts - with the hope that this will reduce the overall consumption and cost of healthcare services and improve health outcomes at the same time. Prepayment, bundled payment, and capitation models are all examples of outcome-based reimbursement that we will be hearing more about, in which 'profit' is measured by cost-savings rather than by revenue.

STRUCTURAL/CULTURAL: Emphasizing overall health improvement among populations will require primary care organizations to reach out to patients that do not typically present to their doctor for care. For example, patients who are at-risk for, but have not yet developed chronic illnesses such as diabetes or heart disease. Or, patients who are not adherent to recommended treatment for existing conditions, such as high blood pressure or HIV. Reaching out to these populations will involve increasing access to care through structural changes in primary practice, such as providing more flexible hours, walk-in services, and electronic contact. It will also require a cultural shift among physicians towards a care-team model that incorporates multiple specialties as well as a role for non-licensed professionals like health education workers and patient-navigators, who provides support with engagement and follow-up care.

In the following pages we will elaborate on the financial and cultural consequences of PBPH and how they will affect psychologists.

The Nitty Gritty of Population Health Management

Population Health Management (PHM) requires a conceptual shift for many healthcare providers, including psychologists, who are used to thinking about client care at a personal and individualized level. Across healthcare disciplines, the standard model of care has previously involved regular one-on-one and face-to-face provider visits, typically occurring in a hospital setting or private clinical practice. As new models of care continue to emerge with an increasing emphasis on cost-effective and cost-sharing practices, PHM is graining traction.

The Institute for Health Technology Transformation (IHTT, 2012) outlines the core components of PHM, which include: defining a subgroup or population, identifying gaps in clinical care, identifying and predicting population-specific risk factors, increasing patient engagement in care, managing care across providers and disciplines, and measuring population-wide clinical outcomes (See *Figure 1).*

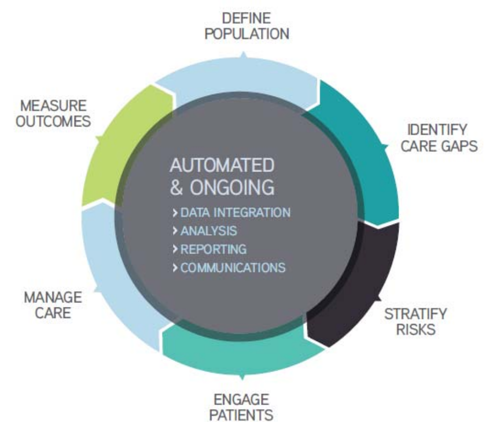

Figure 1. Population Health Management (Institute for Health Technology Transformation, 2012)

With the rise of PHM, the focus is no longer on treating an individual, but treating the *population* or community that you serve. The provider-patient model is rapidly shifting to a practice- population model, which has the potential to alter the way psychologists conceptualize and provide clinical care. Health Service Providers (HSPs) will need to find creative ways to monitor, diagnose, and treat entire populations and communities – which is no small task.

The Institute for Healthcare Improvement has identified a tripartite outcome structure for PHM: improve patient care, increase the overall health of communities and populations, and reduce individual health care costs (Berwick, Nolan, & Whittington, 2008).

Psychologists are well-suited to assist in meeting the goals of PHM. Specifically, more holistic evaluation and treatment of patients necessarily improves clinical care. Of importance, psychology is consistently found to be a cost-effective clinical service, and has the potential to reduce increasing healthcare costs. Finally, psychologists can both assess and address several parts of this model, including social/environmental modification, physical/public health, and (of course) behavior.

PHM may require psychologists reconceptualizing their service delivery models. Under this model of care, psychologists may provide more brief assessments and risk analysis, psychoeducation and consultation (e.g. the "15-minute" session), and group-based monitoring and intervention. Psychological practice may likely become increasingly focused on health issues, broadly defined, in addition to the current emphasis on mental and behavioral problems.

Clinical work may routinely include workshops and seminars for communities, targeted interventions to groups with similar health issues (e.g. obesity, smoking, poor medication adherence), and more group-based practice to address common mental health issues such as depression or anxiety. Focus will increasingly be on preventative care and managing chronic health conditions and outcomes will be measured. Psychologists can be instrumental in designing and implementing wellness and prevention programs, providing group-based screenings and risk assessments, participating in programs to aid in chronic disease management, and addressing mental health issues that are impacting the overall health of their communities.

PHM may look somewhat different for psychologists in a hospital or private practice setting. An example of PHM for a hospital-based provider could be a psychologist running a therapy group in a primary care unit for individuals with diabetes who are non-compliant with their medication. The psychologist would help individ-

uals cope with their illness, provide psychoeducation about medication compliance, and address ambivalence or resistance to treatment. In private practice, a psychologist may be recruited to provide a group-based screening for depression or anxiety in a school or community. This psychologist may then be asked to give a workshop in the community on managing these symptoms and seeking treatment where appropriate.

PHM, Research, & Technology: Beyond HSPs

PHM has broad implications across the profession of psychology, and will impact research- oriented psychologists as well as HSPs. As seen in the model for PHM (Figure *1),* collecting data and measuring outcomes are a critical component to the successful implementation of PM. Ongoing data integration, analysis, reporting, and communication are seen as central to the process.

In order to define populations and move towards community-based treatment, data is needed across the following domains: demographics and parameters of "populations," rates of mortality and morbidity, rates of service utilization and barriers to care, cost of clinical assessments and services, duration of hospital stays and readmission rates, rates of prescription and drug use/ abuse, treatment adherence and medication compliance, social and behavioral determinants of health, and health and quality of life outcomes. It will also be important to be able to track health status over time, preemptively identify at-risk individuals, assess disease prevalence and incidence, and monitor patient experience of care.

A large part of implementing PM involves electronic health records (EHR) and health information technology. EHRs will be instrumental in sharing medical records and clinical data, increasing ease of access, and facilitating communication across treatment settings and providers. Technology is also increasingly being used to facilitate bidirectional communication between patients and providers. Patient engagement is seen as something that occurs on an ongoing basis, outside of routine office visits or phone calls. Outreach and education campaigns can be implemented across various technologies, including email, text messages, wireless biometric devices, and smartphone applications. Examples include mobile health risk assessments, blood pressure tracking devices, medication reminders, and electronic behavioral coaching (IHTT, 2012).

Given their training in data collection and management, statistical analyses, and outcome measurement, psychologists are particularly well-suited to spearheading or assisting with these endeavors.

Show Me the Money: Financial Implications

Coordinated care and initiatives like PM are gaining momentum in the context of healthcare reforms aimed at reducing overall costs. Similar to the shift from individual to population-based care, payment models are beginning to focus more on performance-based pay and cost-sharing than the traditional fee-for-service model. Private insurance companies are supposed to be adopting these new payment models, although we are unclear what they may look like, which may cause more challenges for private practice.

What it Means for You

This new focus on population health management represents a significant shift in how healthcare will be delivered. The driving forces behind these changes seem to be that payors are looking to spread out access and services to more people across the nation, given that resources are finite; that all health care providers will be folded into more of a public health model - even those healthcare providers who have never used this approach-, and research showing that the public would benefit from such an approach which would give more people, more access, to (in theory) more effective services. While this approach is spreading across healthcare, there is not much information about how it will impact practicing psychologists - yet. This is in large part due to the fact that there continues to be a limited focus on behavioral health in the changing healthcare system,

relative to other healthcare services. But one can at least begin to extrapolate based on the impact on healthcare professionals in general.

As part of population health management, it is expected that practice approaches will be redesigned. Most of the changes associated with PHM would require psychologists to be integrated into larger settings and working with teams of other healthcare professionals. While this will be seen as a new opportunity and new role for some, the use of technology to manage populations and the tracking of data (including metrics for purposes of insurance payment and capitated payments), requires new workflows and a change in practice that may become burdensome for some, particularly the private practitioner.

It remains unclear how this will impact those in private practice if PHM does roll out completely. Our Task Force is unaware of efforts to try and integrate private practices into the existing models that are rolling out, or any efforts to develop new of new models of private practice within HCR beyond IPA's (if this is inaccurate please let us know). This is worrisome as there are many psychologists in private practice, particularly in the NYS area. It remains unclear what may happen to those in private practice if PHM turns out to be less viable to the independent practitioner.

We are used to treating people individually. Yet the focus here will increasingly be on keeping populations healthy. Instead of a few people getting intensive services, larger populations will obtain fewer services in the hopes of keeping the population/more people healthier overall. Note that the focus is on using finite resources to manage a large group (population), rather than dedicating intensive resources to a few in an effort to 'cure'. This is quite different than what many psychologists are used to, signaling a shift in how skills will be applied.

Certainly some psychologists will be eager to work within this approach, and are already being trained in PHM approaches, while others will not. To remain competitive in the marketplace, at least a segment of psychologists will likely learn how to work within this new approach to care and adopt new skill sets, such as more frequent use of screening tools, the provision of briefer treatments and treating a cohort of patients and measuring the cohort's progress over time rather than intensive one-on-one treatments. Psychologists may need to obtain additional training if they have limited training in such treatments, and there already many certification programs and online classes available now which are designed for psychologists to learn such skill sets.

While health psychology is the specialty area of the profession most likely familiar with these concepts and skill sets, it will be increasingly useful for those psychologists who are not health psychologists to learn about the psychosocial components of medical well-being, as well as skills like motivational interviewing, to understand and impact the interplay between mental health and physical health. Not everyone will need to obtain specialty training in health psychology, but can obtain basic training regarding bioipsychooscial approaches to treatment of populations. Our recommendation is to avail yourself to these trainings if this is something you are interested in or want to work in more integrated/medical settings, as these skills will be more in demand as the trend of integrated care grows.

It is feasible that some psychologists will continue with the type of practice they have historically provided while adding aspects of PMH into their practice. For example, psychologists may find themselves continuing to work with individual patients but also engaging in more screenings and/or outreach within communities, as this PMH model of care spreads. Psychologists, with appropriate training, may develop an affiliation with a medical practice or hospital (or newly forming ACO's and PCMH's) to treat a defined population (group) of individuals who have a medical problem that is exacerbated by mental or behavioral problems, by which physicians would need the assistance of a trained psychologist. Treatment might be provided at the affiliated facility or at the psychologists practice (assuming the psychologist's services are reimburseable, and that they are able to contract with the medical setting and insurance companies). For those that pursue this, it might mean

that psychologists would manage a group of patients with poorly controlled diabetes, tobacco addiction, or obesity, treating a defined cohort of patients who were identified to have problems requiring behavioral intervention. Or the psychologist may work with the medical team to help alleviate mental health symptoms such as moderate depression or anxiety, in a group setting, for those with co-occurring medical problems, particularly when the psychological symptoms are impacting the ability of that cohort of patients to manage their physical health problems. Services might also include psychoeducational groups or brief group psychotherapy approaches depending on the needs of the medical setting.

As the population management approach spreads, psychologists may be called upon to develop and implement strategies to improve the health of defined populations/subgroups, such as designing systems and programs that integrate both psychological and medical care. Given our expertise in research design and program development, this represents a potential niche area that is ripe for psychologists, and psychologist leaders, to explore.

There is room for opportunity and innovation including, but not limited to, developing ways private practitioners can 'plug' into PCMH's and ACO's in order to keep private practice viable in this new arena. We continue to hope that some entrepreneurial psychologists pursue a legislative and business agenda to create a model whereby psychologists in private practice would be integrated into these emerging systems of care for those in need of longer term treatment. Given there is nothing formally being done in that area, to our knowledge, state psychological associations may want to pool their ideas and resources to develop various models. Or perhaps models that would allow private practices to somehow stand-alone while still incorporating innovative ideas such as PMH. Additionally, there is room still to develop alternative models beyond PCMH's and ACO's which focus more centrally on behavioral health.

PMH represents a huge paradigm shift in how one practices and treats patients, and the only way to have a voice at all is if all psychologists work together, regardless of specialty or setting, and help carve a path for psychologists and the profession in general. While in theory there is an opportunity, politics and policy may limit what we can do on behalf of our patients and our hope is that the profession advocates vigorously for varied and stratified treatments depending on the needs of our patients. As always, the only way to have a strong voice long-term is to remain united as a cohesive field, versus advocating on behalf of only some specialties or practice areas. Patients have varied needs and all needs may not be addressed by brief psychotherapies (10 sessions), or curbside consultations. Alternatively, longer, open-ended treatments may not always be the best use of resources when tackling societal health from a public health standpoint. Connecting with state psychological associations will allow us to pool ideas and person power to work together more effectively, and we hope other SPTA's continue to make efforts to band together, share information, and strategize.

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