When nearly a score of experts get together to decipher what it means to “practice” population-based health, we ought to pay attention. That is exactly what the Advisory Board Company in Washington, DC, did this past summer. After their Population Health Leading Lights Summit, the Advisory Board Company issued a list of 8 insights that I believe are truly worth repeating.

**Insight 1** calls for engaging patients in “their 99%.” This is critical—99% of patient activity is not happening in our view. While we spend millions of dollars on electronic medical records, these electronic systems only track patients when they are “in” the health system, which may be 1% of the time. What are we doing to manage care in the context of the patient’s 99%? We ought to be reaching out to develop community partnerships with senior services, housing agencies, transportation services, medication assistance programs, and the like.

**Insight 2** says that we ought to elevate care management from art to science. The Leading Lights Summit participants called for a unified approach to care management, bringing together patient data, provider data, and payer data, along with predictive modeling, disease registries, and clinical guidelines. They used the analogy of an air traffic control system for managing patient care. Many other healthcare experts have tried to advocate for comparable, systemwide improvements.

**Insight 3** calls for consolidating care management resources for high-risk patients. Apparently, some of the Advisory Board Company integrated delivery participants have created special care centers, focusing exclusively on high-risk patients. Sometimes these are called “special care centers,” which are composed of a team of dedicated physicians and other providers who specialize in caring for high-risk patients. According to the Advisory Board Company participants, accumulating data show an increase in office visits, as well as dramatic decreases in emergency department visits, hospital admissions, and the average daily costs per inpatient stay; in other words, care management truly works when the appropriate resources are brought together for these complex, high-cost patients.

**Insight 4** speaks to the need for a continuum of partners to manage the costs. I was very surprised to learn that, on average, 50% of the total costs, especially of procedurally based cases, are associated with care received postdischarge. Obviously, this means that we have to look outside the 4 walls of the hospital to truly manage the total cost of care. Most integrated delivery systems have an incomplete view of care utilization and quality performance, especially at every postacute facility. The implications are that integrated delivery systems must now begin to measure the quality and effectiveness of care at skilled nursing facilities and related postdischarge venues.

**Insight 5** says that from a governance perspective, it is important to downscale growth expectations. In other words, the aim is to “use lower revenue expectations as a way to focus on maintaining margins and cutting unwanted costs.” To continue delivering appropriate high-quality care, systems will have to increase efficiency and reduce unnecessary utilization. Even in the face of a short-term lower revenue outlook, it is important for health systems to begin to have this proactive strategy.

**Insight 6** says that the true return on investment in population health can only be achieved under a full-risk arrangement. The Advisory Board Company said, “We did not participate in shared savings to make money, we did it to start a cultural transformation. This is a 20-mile march, and the hardest part is the first six inches—between our ears.” When systems migrate to a truly global payment model, they have full control over the premium cost. With that full control comes the obligation to practice based on the evidence, reduce costs per case, and realize a true return on investment.

**Insight 7** calls for an appeal to employers for a broad-
er definition of value. Employers want employees to return to work sooner, and they want predictability in their total spending on healthcare. Some employers, like Intel, have the so-called 5 requirements, which include (1) “right care”—practicing based on the evidence; (2) “right time, right setting”—same-day access to care; (3) “right price”—material decreases in the cost of care; (4) “best life”—rapid return to function and productivity; and (5) “best outcome”—patient satisfaction with experience and care. Who could argue with these 5 requirements?

Finally, Insight 8 calls for a push to standardization across total cost-of-care contracts. I have been a proponent of full transparency for the past 25 years, so this came as no surprise to me. There is simply too much variation in quality and in the various pay-for-performance matrices we currently deploy.

Reference

I have been a proponent of full transparency for the past 25 years, so this came as no surprise to me. There is simply too much variation in quality and in the various pay-for-performance matrices we currently deploy.

As always, I am interested in your views, and you can reach me at david.nash@jefferson.edu.
We Offer More Than Face Time.

If you haven’t heard, GSK is moving forward by aligning our actions with managed care executives’ expectations. This means we are continuously investing in the strategic expertise of our account managers to understand your needs.

Difficult challenges, such as improving population outcomes, abound for managed care organizations—and that’s where the account managers at GSK can bring together experts who offer credible scientific and economic knowledge that can provide insights to inform your solutions.

True collaboration is more than face time—it’s moving forward with solutions that meet your needs.