CHCF CHIP Summary

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CHIP Title: Leveraging the Lessons of the Pandemic to Advance Population Health: How a national medical group serving self-insured employer-sponsored clinics operationalized screening for and addressing population health needs.

Project Description:
The SARS-CoV-2 pandemic has shone a bright light on the need to screen for and address preventive and population health needs in a systematic manner. During the pandemic, declines nationally of up to 80-90% in submitted claims were seen for most preventive services. Patients experienced increased barriers to engaging in care, which often resulted in significant care gaps due to delayed or unmet care needs. The pandemic provided both the challenge and the opportunity to not only expand the ways we provide care, but also change the conversation with our patients and our clients about how they think about and see the value and importance of prevention and population health. The goal of the project was to develop, implement, and iteratively improve an enterprise-wide systematic approach to consistently being aware of, screening for, intervening on, and closing care gaps for our primary-care engaged patients.

Key Findings and Lessons Learned:
We started this project in 2020 and we are at the implementation and scaling stage. By mid-2020, we had launched an enterprise-wide foundation of population health (including 40+ population health metrics, a system to ensure patient attribution to a care team, and patient portal Patient Reported Outcomes screeners). Around the same time, we developed and launched a virtual/in-person hybrid approach to the traditional annual physical visit to provide patients and clinicians choice, convenience, and flexibility with changing pandemic needs. By the end of 2020, we piloted and scaled standardized tools, training, and workflows for conducting active daily management, as well as proactive outreach for patient care gaps. By mid-2021, we built and launched social determinants of health (SDoH) screenings. Finally, by the end of 2021, we showed material improvement in key population health metrics, including over doubling our screening rates for mental health, as well as for breast, colon, and cervical cancer. For SDoH, we screened over 80% of our primary-care engaged patients.

Next Steps:
Our next steps will be to build out our data and metrics to reflect the rest of the journey from measurement to intervention to outcomes for our patients. We will use these data and metrics to generate care insights that will drive our subsequent care interventions and clinical programs. This approach addresses both patient-level health issues, as well as population-level care needs. Ultimately, we expect clinical and financial outcomes, in line with the Quadruple Aim, to show improved health outcomes for the populations we manage.