Introduction

Electronic health records (EHRs) are important tools for many healthcare organizations, enabling caregivers within a care setting to chart and manage patient information and to administer organizational operation. However, using an EHR as your only tool to manage population health will not provide an adequate solution in today’s value-based care environment.

A population health management (PHM) solution needs to enable a wide range of activities that enable you to treat the “whole person” rather than just a condition. You’ll need to proactively identify patients that need care coordination, assign those patients to cohorts based on their clinical, behavioral, and social needs, and institute a care model across diverse settings. In addition, you’ll need to integrate disparate information from across the community so you can analyze and tune your care model, identify additional patients, evaluate how the care coordination programs are performing, and improve outcomes.

This white paper examines how to move beyond simply documenting care information to leveraging EHR data as part of a larger integrated population health management strategy that will help healthcare providers survive and thrive in the new world of value-based care. It discusses the importance of:

- Making EHRs part of a more comprehensive population health management strategy by seamlessly integrating data and reducing friction between disparate systems
- Enabling care providers across the community and care continuum to abandon their siloes and work collaboratively on behalf of patients
- Enabling proactive planning and engagement with multi-disciplinary care teams to improve transitions and care plan execution
- Aggregating information from EHRs and other sources to stratify patients into different risk categories and draw insights from entire patient populations

The Role of EHRs

The EHR as a documentation management tool has become the foundation of today’s healthcare delivery. Almost every healthcare provider uses some type of EHR to chart and document patient care, send and receive orders, and track financial information, insurance data, and other pertinent clinical and non-clinical information to help manage its practice.

However, most EHRs do not look beyond the individual care provided to a patient, or the specific physician, medical practice, hospital, or health system it supports. As soon as you step out of that confined universe into population health management, you’ll need to communicate with service providers across the care continuum who are also involved in the patient’s care. These providers may have different types of software and administrative systems, and some may not even
use EHRs. To be effective, you’ll need a tool that does a different type of work—one that enables collaboration and the documentation and tracking of not only what is happening now, but what needs to happen in the future to support a patient’s health.

**Leveraging EHRs for Population Health Management**

Successful value-based care models require providers across the community—including an entire range of social services in addition to medical and behavioral health providers—to participate as an interdisciplinary team to address the entirety of each patient’s needs. The care team contributes to a body of knowledge contained in universal care plan, and collaborates via common tools and orchestrated workflow to optimize care delivery. These tasks cannot be accomplished by EHRs alone—true population health management requires a tool that can not only document facts and actions as they occur, but provide a platform for ongoing collaboration and proactive care management that will prevent encounters and reduce emergency department usage and hospitalizations.

The best population health management tools can coexist with EHRs, aggregating health information and seamlessly moving it back and forth as needed to support workflow. A high degree of interoperability is necessary to integrate information from disparate providers, reducing friction between systems and providing a comprehensive view of both the patient and the entire population.

**Creating an Integrated Population Health Management Strategy**

Because every organization has unique workflows and requirements, there is no single care standard or strategy that is a recipe for success. However, certain population health management fundamentals—such as collaboration, care management, interoperability, and patient stratification—enable the broader approach to care that’s critical to value-based models. To be successful, you’ll need to be able to leverage the entire population, including those who have not yet crossed the threshold of your organization. This wider lens will help you more effectively stratify and identify patients, and analyze results so you can develop insights on areas for improvement and evolve your workflows and care plans to provide more optimal care.

These PHM fundamentals require organizations to leverage information from EHRs and use it more broadly. Communication and care plans must move beyond the boundaries of a single organization and integrate information from the community to fully address the totality of patient and population needs. To be effective, PHM must enable:

- **Care team collaboration** across disciplines—including medical, behavioral, and social providers—using common tools that enable each team member to do his or her part in a coordinated set of actions that lead to a care outcome.
- **Streamlined workflow** that supports best practices and care standards, with no duplicate entry and seamless switching to EHR information.
- **Proactive management** to prevent episodes, smooth transitions, and reduce ED usage and hospitalizations.
- **Extensive patient classification and stratification** to help providers leverage information from across an entire population to strategically manage at-risk patients, identify areas for improvement, and evolve workflows to provide more optimal care.
- **Assessments and managed consents** that enable patients to be appropriately allocated and enrolled into programs.
- **Smooth interoperability** to harmonize communication among disparate providers and reduce friction.
- **Messages, alerts, and reporting** that enable team members to understand what’s happening in real time plus dig deeper when required.
- **Robust analytics** with quality measures that can provide meaningful insights for improving care and meet operational reporting and compliance requirements.
The Benefits of Population Health Management for Providers and Patients

Patients who participate in a PHM program have a lot to gain. PHM done well provides continual monitoring and risk assessment, so preemptive intervention of serious health risks is not only possible, but is the norm. Community-based care not only accounts for a patient’s medical condition as documented in an EHR, but manages it within the comprehensive context of the patient’s life, accounting for behavioral health factors and social determinants that also affect a patient’s health. This ensures that barriers to wellness are deliberately addressed and coordinated with medical treatment. Care delivered under PHM is evidence-based or empirically validated, so quality outcomes are more consistently achieved as care delivery is normalized across the population.

Care providers in the PHM context span a wide range of care in a patient’s life. Social workers, housing agencies, psychiatrists, primary care physicians, managed care organizations, long-term care facilities, ancillary medical services, hospitals, home care agencies, addiction/recovery services, medical specialists, and even patients themselves may all be enlisted into a care team to coordinate the activities that lead to achieving a patient’s optimal health outcomes.

This wide-tent approach emphasizes teamwork and information sharing. Providing unified views of patients across the care continuum—powered by common tools that enable collaboration among the diverse and disparate care team members—and using analytics to develop insights on effective treatment and intervention are central to PHM success. The benefit to all providers is that, through the team-based approach, each provider is able to account for activity beyond its individual span of control, allowing for more risk to be taken on and truly mitigated, which makes value-based care feasible.

Conclusion

How providers approach PHM matters. A patchwork of existing technologies or a tool that simply documents care as it happens will not enable teams to proactively identify the patients to focus on, determine what care to provide across medical, behavioral and social patient needs, and orchestrate the care across various settings. An ideal population health management solution combines care coordination with robust analytics and smooth interoperability to provide the insights to make patient care more effective and efficient, while reducing risk.

Going beyond the EHR to create an integrated population health management strategy will result in improved clinical outcomes, more effective care teams, better financial results, and ultimately healthier populations.

Ready to learn more?

The GSI Health team is here to help you navigate the complexities and challenges of integrated healthcare. We support any level of implementation, allowing you to crawl, walk, or run toward your objectives in as little as 60 to 90 days or less. Our Client Solutions team offers vast expertise to partner with you along the way for extensive training and support before, during, and after implementation.

Contact us today to find out how we can help you define your population health program.