4 Ways to Achieve Value-Based Care
A Guide for Population Health Harmony

Wellsource
Executive Summary

This is a 4-part series focused on select themes found throughout the Centers for Medicare & Medicaid Services’ value-based, ‘patients first’ initiative.

The Centers for Medicare & Medicaid Services (CMS) continues its heavy focus on value-based care, telling healthcare professionals to work together to put “patients first.” The success of efforts by wellness and population health managers within these industries requires listening to the overarching themes within the initiative: Accessibility, Interoperability, Data analytics, and Engagement.

Does your approach include these essential themes? Here’s why it should, along with some ideas to help you orchestrate patient-centric population health management.

The job of wellness or population health managers is somewhat like that of orchestra conductors who coordinate multiple musicians to produce a unified, pleasing experience. To do this, they need to see the big picture.

They need to know the strengths and weaknesses of each player, and how best to help each of them reach their full potential. They need to know the score – not just the notes, but the overall emotion it is intended to evoke. They must be aware of the acoustics of the venue where the orchestra will play. And they need to know the talent and temperament of the choir members – including the soloists.

Who is in your orchestra? Who are your soloists?

Looking at your population with a “patients first” approach will help you focus on aspects of value-based care that will be at least as rewarding as Beethoven’s Symphony No. 9. It will improve your population’s health. And it will keep you in compliance with CMS directives.

When CMS made healthcare professionals aware of their plan to link reimbursements to whether or not the healthcare entity has a universal electronic health record (EHR), wellness and population health managers took notice. Universal records are one way CMS will ensure the healthcare system puts “patients first” in 2019 and onward.

When you listen to CMS, you will hear their overarching themes. Each plays a different tune, but the overall result is almost magical when they play well together.
PART I.

Accessibility

The era of patient-as-spectator is over

In the traditional healthcare model, patients travel from doctor appointment to lab to specialist—perhaps multiple times—without giving much input beyond talking about their symptoms. They may go to a patient portal to get their test results, but unless they have a medical background they might not understand them. It’s also possible their results from the specialist visit or diagnostic test don’t make it into the same EHR that’s used by their primary doctor. How can you minimize obstacles such as these?

Social scientist and researcher Eric Dishman is a champion of patient involvement. He battled a rare form of kidney cancer, and when six highly qualified physicians met with him they gave him a disheartening prognosis: “You’re not likely to live more than two or three years.” Dishman could have given up. But a friend encouraged him to do more research on his own, so he took the following steps by:

✔ Getting his medical test results.
✔ Learning more about his diseases.
✔ Ensuring his treatment plan was optimized for his personal goals (longevity and lots of skiing).
✔ Taking a self-interested initiative.

He was able to sort through medical jargon and work with his doctors to come up with a treatment plan. He’s a cancer survivor. In the time since his diagnosis, he has helped thousands of others not only access their health information, but also be closely involved with their diagnoses, treatments, preventions, and cures.

Patients like Dishman don’t want to be spectators. They want to contribute to their health in meaningful ways. Patients need to be active partners in their care. But to do that, they must be able to access their health data. All of it. And it must be easy to understand.
Centralized data, in plain language

You’re likely aware of Section 508 Amendment to the Rehabilitation Act of 1973 and the Americans with Disabilities Act that mandates equal access for people with disabilities. But do you know about the Plain Writing Act of 2010? It requires U.S. government agencies to communicate clearly, using plain language their population can understand and use.

The latest CMS announcement about patient-focused care extends the U.S. Government’s accessibility theme. It mandates healthcare entities provide comprehensive, usable data to every patient – and it must be presented in a way that is easily understood.

While the CMS emphasis on understandability expands the plain language requirement to those seeking reimbursement for Medicare and Medicaid insureds, population health managers will be cognizant of literacy among all their populations. Literacy is linked to health outcomes. People cannot make informed decisions about their health unless they understand. The Centers for Disease Control and Prevention (CDC) has established literacy guidelines to help health and wellness professionals best inform and influence individuals to make decisions that will enhance rather than harm health.

Before and After Example of the Plain Writing Act:

**Before:**
The Open Door Initiative is a program based on a simple and fresh attitude: that the CMS desires to better hear and interact with those beneficiaries, providers, and other stakeholders interested in the delivery of quality healthcare for our nation’s seniors and beneficiaries with disabilities. This increased emphasis on responsiveness is captured through an ongoing series of ‘Open Door Forums’ that provide a dialogue about both the many individual service areas and beneficiary needs within CMS.

**After:**
We want to hear from you! Help us improve our service to you. Attend an Open Door forum near you. For information about upcoming forums, visit cms.gov

Source: https://plainlanguage.gov/examples/before-and-after
Economic and social access problems

Literacy is just one component of accessibility that impacts health. Socioeconomic status (SES), environment, and physical barriers are some of the other social factors that impact access to health care. For example, a 2016 survey found that 9 percent of U.S. adults delayed or did not get care because of cost concerns. Of the 12.4 percent of adults who were uninsured, 27 percent delayed care or did not get the care they needed due to cost. Some studies also suggest that a negative bias toward low-income patients could result in restricted care.

One strategy with positive impact is a provider-patient collaborative model such as the Nuka System of Care in Alaska. It has increased patient satisfaction and decreased hospital and clinic visits. Their integrated model actively involves Alaska Natives in its management, utilizes patient-centered medical home care, and ensures access to health and wellness services through care coordination with community agencies.

Patients are like untrained soloists. At times, they might feel isolated from the orchestra. Their voices might be too soft or too loud. They might not understand the musical score like a professional cellist would, for example. They might be distracted by other choir members. A good conductor engages each musician in a way that brings unity and clarity – just like a wellness and population health manager.
Integrated population health management

Population health managers collect and analyze a lot of data bits, gathered from a plethora of sources. Increasingly, population health managers are adding “integrated” to their titles, according to America’s Health Insurance Plans (AHIP).

“It [integrated population health management] is an employee benefits strategy and an approach to care that’s growing in popularity and demand in the United States. It connects pharmacy, dental, vision, and disability data to an employer’s population health platform, which includes any clinical, disease management, or care management programs,” says Jeff Spahr, VP of Specialty Businesses at Anthem, Inc.

Use of Health Impact Assessments (HIAs) and resources like the Community Health Improvement Navigator can help wellness and population health managers create strategies to improve access to health care and access to interventions that will reduce health disparities and create a culture of health within each of their targeted populations.

Other resources include:
- The National Rural Health Resource Center’s Population Health Readiness Assessment
- Resources for Integrated Care library
- Population Reference Bureau (PRB) data and insights, including useful population and health resources

Why is accessibility so important?

A patients-first approach to health care requires a shared decision-making relationship between individuals and the healthcare community. Population health managers should do more than collect medical and social data. They should find out how patients want to approach opportunities for health improvement. Ask patients what motivates them. Discover their definition of a life well lived. And form care plans and wellness plans to align with that information.

Data provides the rhythm for your orchestra – an essential requirement for the collective to play with one voice. But data by itself doesn’t improve access. Population health managers must help patients access and understand it.
Interoperability

Share data intelligently and securely

CMS wants healthcare entities to collect health, behavioral, and socioeconomic data and share it electronically across platforms. It’s a move toward partnering with individuals, as individuals, within segmented populations for a tailored approach to health and wellness. That’s where interoperability comes into play. Players in the healthcare space will have to pool information to make this happen.

CMS is working toward “a health ecosystem where data can flow easily between patient, provider, caregivers, researchers, innovators, and payers,” said CMS administrator Seema Verma. She imagines a day when an individual can access all of their own health and lifestyle data – from birth to present – anytime, anywhere, with the push of a button – and share it with researchers, population health managers, and healthcare providers across the nation.

A repository of information such as envisioned by Verma provides clear benefits to individuals, such as reduced paperwork, fewer duplicate diagnostic tests, and decreased risk of prescription conflicts. But it also benefits population health managers, who will have access to collective data that can do more than manage chronic diseases or treat illnesses. They can use it to predict and prevent illness. Beyond that, a freely shared aggregate of data, combining genomic and lifestyle information with medication efficacy, for example, can improve treatment modalities and develop cures.
A participant-engaged, data-sharing approach to population health eliminates silos of data which hospitals, health plans, and wellness and population health managers operated under for decades. But there’s a privacy and security risk. That’s one reason many health plans still silo their information today with a one-way feed into their proprietary electronic platform. It’s secure. But it’s also inaccessible to others.

Keeping PHI secure in a cloud-based world

The Department of Health and Human Services issued guidelines to ensure ePHI is safe. Yet some providers remain uncomfortable with the concept of universal EHR via cloud sharing, given the privacy and security standards outlined by HIPAA (the Health Insurance Portability and Accountability Act) and the HITECH Act (Health Information Technology for Economic and Clinical Health).

A collaborative EHR network can improve performance, value, transparency, and interoperability. The downside to data centralization is increased risk of cyberattack to health systems and plans. Since 2010, ransomware and other cyberattacks to the healthcare industry have increased by 125 percent. In 2014, the FBI warned of continued cyber intrusions. Recent attacks on Humana highlight the urgent need for health data privacy and security, and health information technology specialists are looking to artificial intelligence (AI), machine learning, and blockchain technology as possible solutions.

Internal practices account for half of all data breaches

It can be argued that cyber security is another reason for collaboration. Health and wellness professionals should share vulnerability information, and ideas for effective ways to keep data secure.

Integration with multiple data points, such as integration with Fitbit® and other wearables, may present security challenges, but the threats from within their own ranks cannot be ignored.

Verizon’s 2018 Protect Health Information Data Breach Report (PHIDBR) found that “internal actors” account for 58 percent of breaches – making health care the only industry where insiders were the major factor. But, the report also showed that paper incidents were more frequent than electronic (27 percent versus 14 percent). Human error accounted for more than a third of the security breaches.

But there’s one thing they should never share: their logon credentials, a practice that is surprisingly common.

Integration with multiple data points, such as integration with Fitbit® and other wearables, may present security challenges, but the threats from within their own ranks cannot be ignored.

Healthcare professionals must know and follow best practices for safeguarding EHRs and other health IT technologies from internal and external threats.
Secure, but not siloed

CMS didn’t detail a specific format when they asked players in the healthcare space to engage in multi-way, universal data exchange. However, in March 2018 the Human API data network announced that they were collaborating with CMS to develop a new Blue Button 2.0 API that will give all Medicare members real-time access to their health data.

Why is CMS laser-focused on universal EHR? Because at present, “nine out of ten communities still operate in a multi-vendor environment, where you have Epic and Cerner and McKesson and MEDITECH and 40 different ambulatory EHRs,” says DirectTrust President and CEO David C. Kibbe, MD, MBA. Analytics by HIMSS (the Healthcare Information and Management Systems Society) found that the average hospital runs 16 distinct EHR platforms. Healthcare entities were complying with governmental policy, but lacked a universal approach.

Privacy and security might not be the only reason for siloed data. Chief of the Office of the National Coordinator for Healthcare Information Technology (ONC) Don Rucker, MD, observed that “Healthcare providers and technology developers may have powerful economic incentives not to share electronic health information and to slow progress toward greater data liquidity.” A 2015 report to congress found that information blocking does, indeed, occur. Examples of information blocking include keeping data in siloed EHRs to retain patients within a healthcare system or charging fees to exchange electronic health information. Rucker advocates for open API software criteria that are “standardized, transparent, and pro-competitive” and notes that the 21st Century Cures Act prohibits information blocking, even in the healthcare or health IT industries.

The data-sharing model outlined by CMS, AHIP, and others envisions a data network similar to the Internet – but far more secure. Distinct bits of data – such as where a person lives, biometrics such as blood pressure, education level, and access to social support – connected together in a collaborative whole. Sort of like an orchestra.

APIs (application programming interfaces) can help health and wellness professionals ensure the data they collect through health risk assessments, diagnostic tests, and evaluations are securely housed and universally accessible. That way, all of them are playing off the same song sheet, as it were.
Get ready for next gen EHRs

The emphasis on interoperability by CMS and ONC means you can expect to see many innovations and enhancements in EHRs, such as open access, streamlined data entry, customized patient-friendly reports, expanded fields for population health management, natural language processing (NLP), machine learning, and built-in predictive data analytics.

Prescription drug monitoring programs (PDMPs) are an example of emerging EHR collaboration possibilities. Pew Charitable Trust conducted focus groups with PDMP administrators to see how drug profiles could be integrated with EHRs to highlight controlled-substance prescriptions via an additional data field, dashboard alert, map, or at-a-glance summary.

So how can you be ready for next generation EHRs? The American Health Information Management Association (AHIMA) recommends you know and follow the Information Governance Principles for Healthcare. In the past, wellness and population health managers have been mostly tactical – focused on the “how” to accomplish the goal of best health within stratified population. Moving forward, strategic governance will become equally important.

You’ll need to look at what data you have, what data you need and where you can get it from, and how you should share the data. You’ll need to make sure your data is clean and includes metadata. And you’ll need to keep the data secure.

Centralized data invites innovation

The same technological advances that work to keep data secure will also shape the future of population health management. Imagine a smart program that will learn to identify depression risk based on a myriad of clinical, environmental, and social data points, and pair it with the individual’s willingness to engage with interventions. Or a future where built-in EHR data analytics can recommend disease management tactics geared to a person’s frailty, history of compliance, social support systems, and confidence in their ability to make a change.

Early identification helps health plans save money too. It makes sense that health plans and wellness companies turn to health appraisals like the WellSuite® IV Health Risk Assessment (HRA). Robust HRAs identify risk factors for preventable chronic conditions and gather information on an individual’s readiness to change. With this information, wellness and population health managers are able to pinpoint and prioritize the best programs and interventions to intervene upstream of costly illnesses. The best HRAs create teachable moments, and recommend simple actions an individual can take to improve health now and in the future. This increases engagement, which is another CMS goal.
Data Analytics

Multiple data points to enhance outcomes

To get a complete picture of an individual’s health, you’ll need to access several data sources. Claims data provides useful information, such as diagnosis codes and service dates. But claims data is a lot like looking in a rear view mirror. You’ll get accurate details about an individual’s past health.

For an accurate look at an individual’s current health, you’ll need to access EHR data. These digital records contain comprehensive real-time information from all points of healthcare contact, such as diagnostic tests and prescriptions. The ONC states that “EHRs have the potential to integrate and organize patient health information and facilitate its instant distribution among all authorized providers involved in a patient’s care.” A universal EHR that is easily accessible by payers, providers, wellness practitioners, and patients can make integrated population health management more effective due to improved care collaboration.

Predictive data for better outcomes

Many EHRs have expanded their databases to include home care notes, social determinants of health, behavioral health information, genomics, outcome studies, and health risk assessment data. Some of today’s robust health risk assessments provide key information that enables wellness and population health managers to identify an individual’s risk for future health problems and implement preventive actions. Including data such as education level, ZIP code, and health habits into electronic repositories invites improved analysis and diagnostics leading to outcomes such as reduced opioid abuse, disease prevention, and suicide prevention.
A 2011 Australian study found that people with low SES “differ significantly from those of high SES in terms of their health behavior, self-perceived health, levels of impairment, chronic conditions, quality of life, and health care.” They have higher obesity rates and worse health. And they tend to turn into high-cost users of health care.

The World Health Organization (WHO) agrees that socioeconomic factors such as environment (work, school, and neighborhood), income and education level, social support network, genetics, and nutrition have “considerable impact” on health. This was observed at least as far back as 1980. Subsequent studies have repeatedly confirmed those findings. A large population multi cohort study and meta-analysis shows low SES to be a strong independent risk factor for chronic disease and early mortality.

Population health involves much more than ensuring access to healthcare services or understandable health records. Socioeconomic factors influence behaviors and impact access to things that influence health, such as access to healthy foods, social support, and healthy environments. Studies show that the socioeconomically disadvantaged have less access to healthy foods, recreation centers, and green spaces.

Unhealthy behaviors that lead to disease tend to cluster by education (unskilled workers) and by ZIP code. A 2015 Health Affairs blog states that a person’s ZIP code is one of the clearest determinants of health and longevity – more so than genetics and race.

Risk Factors of Premature Death

Adapted from www.healthpolicyfellows.org/pdfs/WeCanDoBetter-SchroederNEJM.pdf
Do you know the barriers to healthful living for each individual in your population?

- Do they have access to nutritious food?
- Do they know a healthful meal from an unhealthy one?
- Do they feel safe to take a brisk 30-minute walk in their neighborhood?
- Are they aware of alternative exercises to accommodate any physical limitation they might have?
- How well do they read?
- Do they need assistance in connecting with local agencies for social support?

This data is arguably more important than biometrics alone. The Center for Medicare and Medicaid Innovation (CMMI) initiated the Accountable Health Communities Model (AHC), a five-year program to connect healthcare with health-related social needs. The AHC “is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs, according to CMS. Thirty-one organizations are participating in AHC, which began in 2016. Medicaid encourages population health efforts by providing incentives such as grants and payment reform initiatives.

Finances, environment, culture, and language can present some difficulty when communicating healthy behaviors. You can tell someone to take a brisk walk around the block daily, but what if their culture discourages outdoor exercise?

**You can’t help an individual overcome unhealthy social customs if you don’t know they exist.** What if an individual thinks they can’t afford fruits and vegetables? Your efforts will be more effective when you know their circumstance and present workable solutions.

**How do you get that kind of information? Ask.**

Your health records should have each individual’s address. **Economic data by ZIP code is available through the United States Census Bureau.** You can also use a ZIP code to find out crime statistics and demographics. Additionally, use a health risk assessment that asks questions that cover socioeconomic influencers that impact disease and also meets literacy requirements for your state.
Are you tracking these Socioeconomic Determinants of Health?

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<tr>
<th>Economic Stability</th>
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<th>Education</th>
<th>Nutrition</th>
<th>Community &amp; Social</th>
<th>Healthcare System</th>
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<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
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<td>Safety</td>
<td>Childhood education</td>
<td>Cultural &amp; social norms</td>
<td>Community engagement</td>
<td>Provider languages</td>
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<td>Vocational training</td>
<td>Discrimination</td>
<td>Provider cultural competency</td>
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Health Outcomes
Mortality • Morbidity • Life expectancy • Healthcare expenditures • Health status • Functional limitations

The Workplace Wellness Trends 2017 Survey by the International Foundation of Employee Benefits Plans (IFEBP) identified the top health conditions that impact health plan costs. They are:
- Diabetes
- Cancer
- Obesity
- Arthritis/Back/Musculoskeletal
- Heart Disease
- High Blood Pressure
- Depression/Mental Illness
- High Cholesterol
- Smoking
- High-Risk Pregnancy

“About half of employers use disease management programs to help manage the costs of these very expensive chronic conditions,” said Julie Stich, IFEBP associate vice president of content. “In addition, about three in five employers use health screenings and health risk assessments to help employees identify and monitor these conditions so that they can be managed more effectively. Early identification helps the employer and the employee.”
Granular stratification

There will always be a need for wellness and population health managers, but the approach will shift to a more granular focus in the near future. Population health managers will be able to stratify people by ZIP code, health condition, DNA variations, self-perception of health, and other data that impacts both risk and effectiveness of intervention efforts.

This is Precision Medicine, an approach to health and wellness that “considers individual variability in genes, environment, and lifestyle” as it delves into the field of cancer, and “ultimately into all areas of health and health care.” This approach to health care is at the forefront of medical research. The All of Us Research program began recruiting participants in Summer 2018.

Within two months, thousands of U.S. adults joined the cohort, answering questions about their lifestyle and giving researchers permission to access their medical records, DNA, and wearables data. All of Us researchers intend to radically change how diseases are diagnosed and treated.

The Sync for Science pilot is a national collaboration among EHR vendors that supports precision medicine. The goal is a consistent workflow that will allow patients to donate their EHR data to research.

If you are interested in getting in on the ground floor of this data-sharing model, ask your EHR vendor if they are involved in the project. Your organization might be able to be a pilot site.

Incorporating genetics, health claims, change readiness, and social and behavioral factors into your analysis will increase your chances of fine-tuning and implementing successful, cost-effective strategies for health.
Engagement

Improving outcomes with technology

A “patients first” approach requires more than simply giving patients access to their information. It also means that those within health and wellness intentionally engage with and empower patients.

Wellness and population health managers are uniquely qualified for this task. They routinely analyze data, stratify populations into cohorts based on factors such as geography or pre-existing conditions, sub-categorize populations based on risks, design intervention and care plans, collaborate with community agencies, proactively reach out to colleagues within the health and wellness sphere to provide optimal care, and skillfully achieve patient buy-in, engagement, and compliance.

Wearables have revolutionized the wellness industry. A recent Accenture study found that 90 percent of individuals are willing to share their wearable health data with their doctors.
More than two-thirds of hospitals are currently using some form of telehealth services – a 10 percent increase over a two-year period. Another 13 percent say they plan to implement telehealth within the year. Telehealth can be telephonic, videoconferencing, wireless communication, or remote monitoring.

Telehealth is increasingly used with home-dwelling older adults, people with chronic conditions, and rural individuals. Case Examples of AHA Members in Action show these services provide essential access. And they may save health plans money. One randomized study found cardiology telemedicine consults lowered costs by an average of $500 per Medicaid patient.

Telehealth as currently practiced may be the beginning of greater disruption to health care. Some researchers, like Eric Dishman, envision a future where care at home is the default mode (versus a clinic or hospital).

“Smartphones that we’re already carrying can clearly have diagnostic devices like ultrasounds plugged into them,” he said in a 2013 TedTalk. With AI advances, an implantable device that monitors blood sugar may someday also wake you up and advise you to eat to maintain glucose control. A wearable may take vital signs and dispense an opiate antidote if needed.

But if you want patients to keep appointments with you, a health coach, or physician, the best way – today, at least – is to text them a reminder. A 2015 nationwide U.S. study found that only half of people who own a mobile phone download health apps, and less than half of those people actually use them. Email and texts are better ways to engage with your population. A Kaiser Permanente study linked provider-generated patient emails to better health outcomes.

“The way healthcare organizations communicate with people is changing, as individuals become more and more sophisticated about using information technology to make health-related decisions,” said Stuart Wells, FICO’s chief product and technology officer. In their 2014 study, 80 percent of smartphone owners wanted to receive healthcare alerts, such as reminder texts for upcoming appointments or to take medications.

Adults see value in both health wearables and EHRs, and are increasingly positive toward AI-health services. The timing is perfect to integrate wearables information into electronic records.
Automated algorithms and AI-generated email messages won’t replace wellness and population health managers – at least not anytime soon. After all, an orchestra – no matter how well prepared – still needs a conductor. At least one market watch website predicts “the increasing focus on value-based medicine, expansion in emerging economies, and rising focus on personalized medicine based on analytics are likely to offer lucrative growth opportunities for players in the population health management market.”

CMS has laid down a value-based, patients-first rhythm. All the players are there – including the soloist. It’s your job to coordinate the players impacting the health of stratified populations and individuals within them.
Here are 5 takeaways to help you succeed:

1. **Consider patients as partners in health.**
   You already coordinate efforts with healthcare entities, government agencies, and community organizations. It’s time to include patients as team members. Find out each individual’s:
   - Preferred engagement method (e.g., text, phone calls, video-conferencing)
   - Degree of understanding about their condition
   - Treatment goals
   - Health habits

2. **Connect to the data universe.**
   CMS envisions a future where a patient’s health data is accessible to each individual anywhere and at any time. It must also be accessible to healthcare providers and population health managers via a universal EHR. Share the data you collect and the population health plans you create with these stakeholders, in plain language that is understandable to all.

3. **Collect the right data.**
   Wellness and population health managers need more data than a medical condition and income level to effectively stratify populations and match individuals with interventions that will result in the best outcomes. As you stratify populations, consider more than disease.

4. **Embrace technology.**
   Future AI that can take a deep dive into EHRs and intercept chronic conditions will transform the future of population health. So will technological advances that enable patients to take a more active role in their diagnosis and treatment. Rest easy. You don’t need to be a software developer or IT expert. Just keep up with the technological advances that will continue to disrupt how data is analyzed and care is delivered.

5. **Communicate proactively.**
   Engage partners in all areas – healthcare agencies, pharmacies, behavioral health entities, government organizations, schools, community facilities, and individuals – to improve conditions that increase the risk of disease. Interact proactively with populations to maximize compliance, and utilize outreach efforts such as telehealth, patient portals, secure text and email messages, and conveniences such as retail clinics and free tax services for low income families.
About Wellsource

For four decades, Wellsource has been personalizing population health by designing innovative Health Risk Assessments that are grounded in modern evidence-based medicine. Wellsource uses the power of technology to drive informed decisions with actionable data for health plans, wellness organizations, and companies committed to improving wellness. Our WellSuite® IV Health Risk Assessments for the Workforce, for Medicare, and for Medicaid are NCQA certified and used for predicting health risks and reducing avoidable costs.

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