Advancing the Population Health Improvement Model

DMAA: The Care Continuum Alliance promotes a proactive, accountable, patient-centric population health improvement model featuring a physician-guided healthcare delivery system designed to develop and engage informed and activated patients over time to address both illness and long term health. DMAA members believe that managing health requires the active, integrated involvement of all health care professionals coordinated with the patient and their caregivers and families. We offer these principles to describe the elements of this fully-connected health system, leveraging teams of care providers, focused on proactive, coordinated, quality health care.

The population health improvement model highlights three components: the central care delivery and leadership roles of the primary care physician; the critical importance of patient activation, involvement and personal responsibility; and the patient focus and capacity expansion of care coordination provided through wellness, disease and chronic care management programs. The convergence of these roles, resources and capabilities in the population health improvement model ensures higher levels of quality and satisfaction with care delivery. Further, coordination and integration are important tools to address health care workforce shortages, individual access to coverage and care, and affordability of care.

The accountability for delivering and coordinating appropriate cost-effective care and the credit for achieving targeted improvement and goals for population health must be explicitly recognized and proportionately rewarded. To this end, the population health improvement model envisions optimization of both physician office practices and other services that improve population health where demonstrated to add value To best achieve this, payers, purchasers, patients and their advocates and other members of the health care team must promote and ensure appropriate reimbursement schedules for cognitive services, care coordination, referral activities and adherence to desired processes, such as the use of evidence-based clinical guidelines.

Key components of the population health improvement model include:

- Population identification strategies and processes;
- Comprehensive needs assessments that assess physical, psychological, economic, and environmental needs;
- Proactive health promotion programs that increase awareness of the health risks associated with certain personal behaviors and lifestyles;
- Patient-centric health management goals and education which may include primary prevention, behavior modification programs, and support for concordance between the patient and the primary care provider;

- Self-management interventions aimed at influencing the targeted population to make behavioral changes;
- Routine reporting and feedback loops which may include communications with patient, physicians, health plan and ancillary providers;
- Evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall population health.

The population health improvement model:

- Encourages patients to have a provider relationship where they receive on-going primary care in addition to specialty care;
- Complements the physician/practitioner and patient relationship and plan of care across all stages, including wellness, prevention, chronic, acute and end-of-life care;
- Assists unpaid caregivers, such as family and friends, by providing relevant information and care coordination;
- Offers physicians additional resources to address gaps in patient health care literacy, knowledge of the health care system, and timeliness of treatment;
- Assists physicians in collecting, coordinating and analyzing patient specific information and data from multiple members of the health care team including the patients themselves;
- Assists physicians in analyzing data across entire patient populations;
- Addresses cultural sensitivities and preferences of individuals from disparate backgrounds;
- Promotes complementary care settings and techniques such as group visits, remote patient monitoring, telemedicine, telehealth, and behavior modification and motivation techniques for appropriate patient populations.

Accountable measurement of progress toward optimized population health should include:

- Various clinical indicators, including process and outcomes measures;
- Assessment of patient satisfaction with healthcare;
- Functional status and quality of life;
- Economic and healthcare utilization indicators; and
- Impact on known population health disparities.

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DMAA: The Care Continuum Alliance supports this population health improvement model to provide the elements of a fully-connected health care system to provide all members of the health care team essential tools to ensure proactive, coordinated, quality health care.