701 Pennsylvania Ave. N.W., Suite 700
Washington, D.C. 20004-2694
(202) 737-5980 • (202) 478-5113 (fax)

dmaa@dmaa.org • www.dmaa.org

***Successful Strategies and Processes for Population Health Improvement***

Population health improvement 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;
- 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 population health improvement 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.

**Population Health Improvement**

Population health aims to improve the health status of a target population and can reduce health inequities among population groups.

Population health encompasses the realization that a range of physical, environmental, and socioeconomic factors contribute to health. By successfully managing health influences on individuals, population health endeavors to affect the complete physical, mental and social well-being of a target population. Process components of successful population health improvement approaches include:

Population identification strategies and processes; *common approaches include, but are not limited to, analysis of:*

- *Medical claims data*
- *Drug utilization data*
- *Health risk assessment (self-reported) data*
- *Risk score data (e.g. CMS HCC codes)*
- *Diagnostic Laboratory tests [HDL, LDL, FBS, etc.]*
- *Risk stratification and predictive models*

Comprehensive needs assessments that assess physical, psychological, economic, and environmental needs. *Common approaches include, but are not limited to, use of:*

- *Validated physical assessment tools (e.g. SF-12)*
- *Validated tools to screen for depression (e.g. the PHQ-9)*
- *Socioeconomic assessment to identify possible barriers to accessing health and wellbeing services, including use of residence location information*
- *Case management assessment tools to identify environmental needs*
- *Self management and disease patient knowledge assessment*

Proactive health promotion programs that increase awareness of the health risks associated with certain personal behaviors and lifestyles; *common approaches include, but are not limited to:*

- *HRA feedback*
- *Nurse or other health care professional coaching via the telephone/Internet*
- *Nurse or other health care professional coaching in a face-to-face setting*

- *Provision of health education materials (generally by mail)*
- *Access to Web-based risk calculators and educational content*
- *Assistance accessing locally based health and wellbeing resources*

Patient-centric health management goals and education which may include prevention, behavior modification programs, and support for concordance between the patient and the primary care provider; *common approaches include, but are not limited to:*

- *With respect to primary prevention of disease: providing educational information to patients and providers on prevention of chronic diseases through lifestyle changes (e.g., weight loss or exercise) or treatment of risk factors (e.g., control of hypertension through medication)*
- *With respect to secondary prevention of disease: preventing recurrent complications of diseases or disease exacerbation by supporting patients to adhere to care plans created by their providers and care managers*
- *Use of "contracts" for lifestyle changes developed collaboratively with consumers, their caregivers, and their providers*
- *Providing support and encouragement for attainment of lifestyle changes articulated in "contract," recovery plans, and other approaches that facilitate behavioral changes*
- *Engaging providers in goal-setting process*
- *Providing both patients and providers with feedback on progress toward goals*

Self-management interventions aimed at influencing the targeted population to make behavioral changes. *Common approaches include, but are not limited to:*

- *Use of behavior change models (e.g., Prochaska)*
- *Continuous feedback using remote patient monitoring technologies*
- *Web-based tools*
- *Motivational interviewing techniques that establish personalized goals for better health and wellbeing*
- *Knowledge about accessing and using locally based resources for supporting desired behavior changes and attaining goals for better health and wellbeing*

Routine reporting and feedback loops which may include communications with the patient, caregivers, providers, health plan and ancillary providers. *Common approaches include, but are not limited to:*

- *Routine reports to providers indicating status in the population health program*
- *Reports to providers on the status of each patient in the program*
- *"Alerts" to providers about acute changes in a patient's health*
- *Decision support for providers based on evidence-based feedback*
- *High-level management reports and patient-level reports to payors*
- *Electronic medical records that are maintained by either providers or patients that facilitate continuity of care and patient-physician communication*

Evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall population health. *Common approaches include, but are not limited to:*

- *Creation of a "dashboard" for the population health program that includes metrics in each of the following areas:*
    - *Clinical process measures*
    - *Clinical outcome measures*
    - *Healthcare service utilization*
    - *Patient functional status*
    - *Cost of care*