CMT CLINICAL NEWS BRIEF

CMT Embraces Population Health Management with New *ProAct* Features

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There is increasing evidence that examining health outcomes of populations as a whole, rather than individuals, is a more effective way to improve quality and cost of care. Issues common to subsets of the population can be prioritized based on various factors ultimately allowing more informed decisions to be made.

New features available with the current edition of ***ProAct*** support this new approach of population health management.

Population health management (PHM) requires providers to utilize data to choose which patients to select for specific evidence-based interventions and treatments. Care can then be tailored to those most in need of particular services, ensuring that adults with serious mental illness, for example, are getting the right services at the right time for their conditions. Besides being a route to value based care, legislation is also a major driver of PHM. The Affordable Care Act (section 2703) explicitly requires health homes to utilize a PHM approach. Services need to be quality-driven, cost-effective, culturally appropriate, person- and family-centered, and evidence-based, ensuring that a full array of services are available and coordinated, and that health information technology is used to look at individual and population level care quality.

Fundamental to the PHM approach is to stratify the population into well-defined risk groups and then create differential care strategies based on each group's needs. Costs can be reduced by preventing those who are well from becoming ill and improving quality of life and enhancing health outcomes for those who have developed one or more chronic condition. For those with a chronic condition, efforts are focused on minimizing or preventing the progression of disease. This translates into ensuring that recommended evidence-based care is provided (the Institute of Medicine's Crossing the Quality Chasm report, found that about 50% of Americans with chronic illnesses are not receiving recommended care). ***ProAct's*** *Health Alerts* and *Quality Indicators* are all anchored in evidence-based medicine or national health quality standards and include a robust set of alerts aimed particularly at those with mental health, developmental disabilities, or substance use comorbidities.

"The population health improvement model highlights three components: the central care delivery and leadership roles of the health professional; 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."[1]

1. Define Population: The first step in the cycle is to choose a population of interest. Using ***ProAct's*** Registry window, users hone in on groups based on diagnosis, service utilization or other criteria.

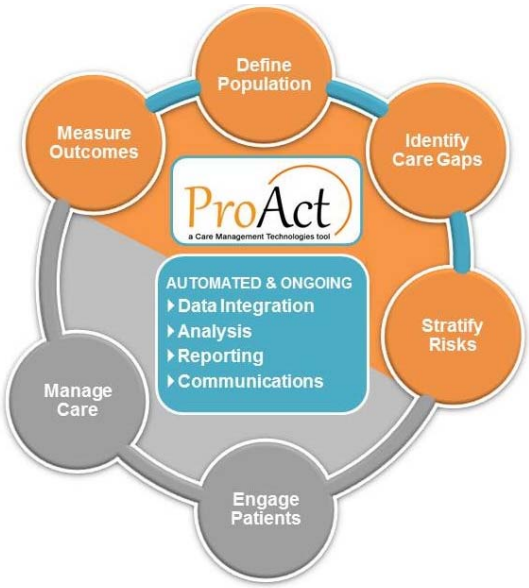
2. Identify Care Gaps: Once a population has been identified ***ProAct's*** *Quality Indicators* and *Health Alerts* are applied to characterize gaps in guideline based care.

3. Stratify Risks: The next step is to stratify the ***ProAct*** identified care gaps based on criteria that can include high risk or prevalence. Strategies are then developed to address the most important care gaps.

4. Engage Patients: Successful strategies to remedy care gaps include motivating and collaborating with patients to help them understand care plans and the importance of complying with recommended guidelines.

5. Manage Care: Assignment of health team roles and responsibilities are made as the strategy is implemented.

The Population Health Management Cycle[2]



6. Measure Outcomes: Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines. ***ProAct*** can incorporate a variety of user collected outcomes data.

[1] Care Continuum Alliance, "Advancing the Population Health Improvement Model," http://www.fiercehealthit.com/story/hennepin-health-project-looks-build-countywide-ehr-program-national-implica/2012-01-10.

[2] Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare. Institute for Health Technology Transformation. 2012

To learn more about how CMT can support your organization's movement to Population Health Management, contact:

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