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DMAA: The Care Continuum Alliance

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Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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Care Coordination in the Context of a Population Health Management Model

By Tracey Moorhead

Population health management encompasses a broad continuum of care services, from wellness and prevention through disease management and complex case management. This continuum of care represents the evolution of the traditional disease management industry from one focused on managing single chronic conditions to one focused on managing multiple comorbidities. It recognizes that early intervention can keep healthy people well, help those who are at risk stave off the development of chronic conditions, and educate those with chronic illnesses about condition management techniques to mitigate complications and exacerbations.

DMAA: The Care Continuum Alliance provides services along all points of this continuum - from wellness to population health management to disease management - via its member organizations, which include health plans, labor unions, employer organizations, pharmaceutical manufacturers, pharmacy benefit managers, health information technology innovators and device manufacturers, physician groups, hospitals and hospital systems, and academicians. These diverse organizations share DMAA's vision of aligning all stakeholders to improve the health of populations. Members seek to maintain and improve health care quality and restrain health care costs by providing

targeted interventions and services to individuals who are well, at-risk, or managing 1 or more chronic conditions.

The expansion of services to encompass a full continuum of care, along with the dramatic expansion of population health management providers, highlights the importance of careful coordination of services and providers. With the evolution from single-state disease management to population health management strategies, the focus is on techniques and tools for improved care coordination.

Population Health Management Model

On behalf of the population health management industry, DMAA: The Care Continuum Alliance advances a population health improvement model that contains the elements of a fully-connected health care system to provide all members of the health care team with essential tools to ensure proactive, coordinated, quality health care. The population health improvement model highlights 3 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 for increased care coordination

engendered by 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.

Accountability must be assigned for delivering and coordinating appropriate cost-effective care. Likewise, the achievement of targeted improvement and goals for population health must be explicitly recognized and proportionately rewarded. To this end, the population health improvement model envisions optimizing physician office practices and other services that improve population health and 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;

(continued on page 2)

- comprehensive assessments of 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 patients, physicians, health plans, 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 supports care coordination goals in a wide variety of ways. First and foremost, it encourages patients to have a provider relationship whereby they receive ongoing primary care in addition to specialty care, and complements the physician/practitioner and patient relationship and plan of care across all stages, including wellness, prevention, chronic, acute, and end-of-life care.

The model supports physicians by offering additional resources to address gaps in patient health care literacy, knowledge of the health care system, and timeliness of treatment. It also provides technical assistance to physicians – from collecting, coordinating, and analyzing patient-specific information and data from patients and multiple members of the health care team to analyzing data across entire patient populations.

Further, the model assists unpaid caregivers, such as family and friends, by providing relevant information and

care coordination, and by addressing cultural sensitivities and preferences of individuals from disparate backgrounds.

Finally, the model promotes care coordination by promoting complementary care settings and techniques, such as group visits, remote patient monitoring, telemedicine, telehealth, 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 health care; functional status and quality of life; economic and health care utilization indicators; and impact on known population health disparities. These indicators can demonstrate the effectiveness of coordination activities across services and providers.

Care Coordination in Population Health Management

As already described, population health management is a system of coordinated health care interventions and communications for at-risk and chronically ill populations. Population health management supports care coordination by facilitating/supporting integration across providers or care settings to link chronically ill individuals and their families with health education and appropriate services and resources. Care coordination also includes interrelationships across health care services and strategies, from primary prevention and acute care to chronic and end-of-life care. As such, care coordination is a central component of population health management.

The National Priorities Partnership, convened by the National Quality Forum (NQF), has established 6 key goals to transform health care and create and expand world-class, patient-centered, affordable care by eliminating waste, harm, and disparities, and thereby reducing disease burden. Care coordination to ensure patient-

centered, high-value care is among these priorities and associated quality goals include improved communication and medication management during transitions in care and reductions in 30-day readmissions and emergency department visits.

The NQF defines “care coordination” as “a function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time. Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, high-quality patient experiences and improved health care outcomes.”

The NQF has designed 5 care coordination domains: 1) health care “home”; 2) proactive plan of care and follow up; 3) communication; 4) information systems; and 5) transitions and “handoffs.” The population health model encompasses these 5 domains to achieve improved care coordination.

Summary

The population health improvement model represents the evolution of traditional, single disease state management by facilitating and ensuring patient-focused care coordination to improve the quality of health care provided to individuals across the continuum of care and services. The population health improvement model is closely aligned with the National Priorities Partnership’s efforts to improve care coordination. Aligning the goals and components of care coordination offered by DMAA: The Care Continuum Alliance, the NQF, and the National Priorities Partnership enables the dissemination of a comprehensive tool that all stakeholders can utilize as they transition from single condition programs, created and delivered in a silo, to whole person, whole population health management.

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