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Michelle Shaljian, 347-754-1692, michelle@pcpcc.org

Health IT Plays Critical Role in Improving Population Health,
Says New Report Released at National Primary Care Conference

Report reviews best practices and recommends 10 essential health IT tools for
population health management in medical neighborhood

(Washington, DC) – OCTOBER 14, 2013 – In response to increasing collaborations among traditional medical providers and community organizations, the Patient-Centered Primary Care Collaborative (PCPCC) released a new report to support primary care clinicians in their efforts to adopt a population health approach that leverages health IT solutions. The report titled, “Managing Populations, Maximizing Technology: Population Health Management in the Medical Neighborhood,” was released today at the PCPCC’s Annual Fall Conference (October 14 – 15) in Bethesda, MD.

“This report offers a unique, comprehensive view of health IT-enabled population health management that is built on a foundation of the patient-centered medical home, and further extends into the medical neighborhood,” said Marci Nielsen, PhD, MPH, the PCPCC’s CEO. “Health care and community stakeholders must adopt a population health model that addresses the social determinants of health, including population-based interventions that anticipate the needs of patients, track patterns of illness, measure the effectiveness of interventions, and assess patient risk.”

A relatively new term, the medical neighborhood is centered around the patient-centered medical home (PCMH), which serves as an individual’s primary care “hub.” The medical neighborhood is even more inclusive, connecting primary care practices to hospitals, home health agencies, mental health providers, as well as community organizations that encourage healthy living, wellness, and safe environments. While strengthening the medical neighborhood requires significant efforts in governance and community organizing, the report emphasizes that the widespread adoption of health IT will be critical to its success.

“This report is an essential primer for physicians and practices that are considering partnerships with a broad range of organizations in their community,” said Ted Epperly, MD, President and CEO of The Family Medicine Residency of Idaho, and Co-Chair of the PCPCC’s Care Delivery & Integration Center. “Many providers are already working with neighboring medical providers in an integrated and coordinated manner, but should also engage with schools, employers, public health agencies, faith-based organizations, and others in order to provide the level of person-centered care that is essential to improving the health and well-being of individuals, families, and communities.”

Recommended Top 10 List of Health IT Tools for Population Health Management
The report presents an overview of the population health approach, and provides a number of health IT tools that are embedded in the five key attributes of the PCMH and medical neighborhood. It also includes a recommended “Top Ten List” of health IT-based population health management tools, including:

- Electronic health records (EHRs)
- Patient registries
- Health information exchange
- Risk stratification
- Automated outreach
- Referral tracking
- Patient Portals
- Telehealth / telemedicine
- Remote patient monitoring
- Advanced population analytics

“Health IT offers an essential infrastructure and solutions for population health management that can be adopted incrementally over time, and help providers continue on a path of quality improvement and primary care transformation,” said David B. Nash, MD, MBA, Founding Dean of the Thomas Jefferson University, Jefferson School of Population Health, and a member of the publication’s review committee.
The report also includes case studies of population health management from a broad range of practices throughout the country, including Twin City Pediatrics, a small practice in Winston-Salem, NC, Union Health Center, a community health center in New York, NY, and Bon Secours Medical Group, an Accountable Care Organization (ACO) in Richmond, VA.

“As this report confirms, population health management technology is a prerequisite for primary care practices that want to identify health trends in their communities, exchange information across organizations, coordinate care as patients transition between providers, and deliver secure communications between providers and their patients,” said Richard Hodach, MD, a member of the publication’s review committee and Chief Medical Officer of Phytel, a population health management company. Phytel contributed experience from its broad base of PCMH clients to validate the report’s findings.

A population health approach is also critical for organizations like ACOs that are challenged with balancing financial risk, improving quality of care, and reducing costs. “By using tools like risk stratification and automated outreach, our care teams can pinpoint individuals that are at high risk for readmission, and follow up with them quickly to reinforce discharge instructions, reconcile medications, and schedule a follow up appointment with their primary care provider,” said Robert Fortini, PNP, Chief Clinical Officer, Bon Secours Virginia Medical Group. “We’re proud to say our 30-day readmission rate for PCMH patients has remained below 2% for over two years.”

However, as the report points out, despite upward trends in health IT adoption, there is still a lag in implementing a sophisticated PHM approach. For example, in an international comparison, 50 to 90 percent of doctors in developed countries routinely use advanced health IT tools, such as computerized alerts, reminder systems to notify patients about preventive or follow-up care, and prompts to provide patients with test results. In the U.S., just one in four doctors in the US has such a system, and 40 percent or more reporting they have neither a manual nor electronic system for such tasks.

“The report not only presents a number of opportunities for organizations to be successful in population health management, it also points out key barriers that are preventing a widespread adoption of innovative tools and technologies,” said Jill Hummel, Vice President, Payment Innovation at WellPoint, Inc. and PCPCC board member. “This report presents a realistic assessment of the current state of population health management, and its implications for payment reform, workforce education and training, patient engagement, and the health IT industry.”

The report will be released at the PCPCC Annual Conference today, October 14th, and will be the focus of a panel session on Tuesday, October 15th from 10 AM to 11 AM, and 11AM to 12:15 PM at the Hyatt Regency Bethesda. Panelists include Kevin Dorrance, CDR, Chief, Internal Medicine, and Assistant Deputy Commander, Medical Services, Walter Reed National Military Medical Center; Brian Parker, President, Practice iQ, Aetna; Robert Fortini, PNP, Chief Clinical Officer, Bon Secours Medical Group; and Tom Frosheiser, Senior Vice President, Phytel.

About PCPCC (www.pcpcc.org): Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). The PCPCC achieves its mission through the work of our five Stakeholder Centers, led by experts and thought leaders who are dedicated to transforming the U.S. health care system through delivery reform, payment reform, patient engagement, and employee benefit redesign. Today, PCPCC’s membership represents more than 1,000 medical home stakeholders and supporters throughout the U.S.

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