

# Population Health Management

POPULATION  
HEALTH

## Closing the Loop to Deliver Superior Care

The Allscripts Population Health Management suite of solutions enables healthcare organisations to deliver high quality care—integrated across the continuum—while lowering costs and enhancing patient and provider satisfaction. Over the past decade, the focal point of healthcare delivery has shifted dramatically to a patient-centric system.

*“Having the right data and the ability to intelligently manage chronic diseases at the point of care rEMResents a dramatic shift toward better health for the entire population.”*

Rasu Shrestha, MD,  
VP, Medical  
Information Technology  
Medical Director, Interoperability &  
Imaging Informatics UPMC



This migration is accelerating—and widening, to include care settings such as a patient's home and workplace. Healthcare no longer happens at a defined or isolated point in time. It's continuous and centered around the patient, not a specific venue for care.

We deliver a suite of revolutionary population health management solutions serving as a foundation for this new healthcare model.

- Providers and navigators create care plans in Care Director™...
- ...which involve patients in their health through the Allscripts FollowMyHealth™ patient engagement platform...
- ...which become available to providers at the point of care across the greater care community via dbMotion™ EMR Agent and Collaborate...
- ...where it can be used for real-time clinical-decision making and Population Health Analytics—and then fed back into the cycle to produce quality outcomes and drive

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## 4 Components of Successful Population Health Management

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KLAS, a leading industry analyst firm, identified four components critical for effective population health management—functionality healthcare organisations must consider when selecting their solutions partner:

- **Data Aggregation:** Combining patient data from disparate sources
- **Risk Stratification:** Segmenting populations to prioritize interventions
- **Care Coordination:** Directing care providers' efforts
- **Patient Outreach:** Engaging patients in their care aggregate patient data, stratify risk, coordinate care and engage patients.

© KLAS Research, Population Health Management  
2013: Scouting the PHM Roster; Performance  
Report October 2013

## Building a Successful Population Health Strategy

*Our suite of population health management solutions equips providers and healthcare organisations to successfully monitor and manage patients along the entire care continuum.*

The **dbMotion semantic interoperability platform**, ranked as the top ambulatory health information exchange solution by Black Book, aggregates clinical information from disparate sources—and then harmonizes the data, delivering it in the provider's native workflow in an actionable format.

With the **dbMotion EMR Agent**, clinicians don't need to search for patient information outside of their EMR—new clinical information comes directly to them. When information not found in the clinician's EMR shows up in the wider community record—"delta" data elements—EMR Agent alerts users and allows them to pull select information back into their native EMR.

**dbMotion Collaborate** enables providers to shift from an individual patient view to a practice-centric population view. It aggregates lists of patients based on current need—identifying all patients noncompliant with their diabetes care plan, for instance. Providers, care coordinators and practice managers can view their patients' information in real time, enabling them to manage and plan care, review status, and communicate medical events across the broad care community.

All caregivers—anywhere along the continuum—who interact with patient gain full visibility into the patient's care plan with **Care Director**. Once a care plan is created in the EMR, Care Director helps clinicians build assessments, monitor results, track outcomes, and make modifications to address gaps and individual needs.

Patients become active members of the care team with access to the **FollowMyHealth** patient engagement platform. FollowMyHealth is EMR-agnostic to integrate with all systems across the enterprise and simplify patient access regardless of the provider's software. Through the portal, patients can fill out forms, view test results, refill prescriptions, request appointments, pay bills online and communicate with physicians.

**FollowMyHealth Achieve** extends the value of the patient engagement platform. Leveraging consumer wireless technologies and the FollowMyHealth portal, Achieve enables providers to engage patients directly in the ongoing management of their care—monitoring compliance with care plans remotely and initiating interventions in a timely manner to influence behavior and impact outcomes.

Drawing on data available through the dbMotion platform, the **Population Health Analytics** framework provides an agile solution to meet rapidly growing analytics and reporting requirements. Prebuilt reports, dashboards and versatile workflow support quality improvement programs and increased efficiencies. Our **Clinical Analytics Gateway** enables organisations to maximize analytics packages, serving as a conduit for aggregated, harmonized clinical information for enhanced population management and risk assessment.

## Population Health Management Solutions in Action

*Patient Beth Allen, previously diagnosed with CHF, sees her cardiologist for a routine check-up. The clinician notes that Beth has gained weight and that her blood pressure is elevated. He adjusts Beth's medication, and enters an order and care plan in the EMR. These become available to other clinicians at the point of care via dbMotion EMR Agent, dbMotion Collaborate and Care Director—and to Beth through FollowMyHealth Achieve. Beth's Achieve goals include monitoring her weight daily, which she does utilizing a wireless scale integrated with the FollowMyHealth portal. The care team at the cardiology practice monitors her results—and reaches out two weeks later when they are alerted to a weight gain of five pounds, which suggests Beth's CHF is getting worse. Later that month, Beth also sees her GP for what she assumes is a respiratory infection. Because the GP can access complete, harmonized clinical information at the point of care, however, he recognises that her shortness of breath is not an infection but a symptom of her CHF. He prescribes diuretics for Beth and consults with the cardiologist—who also sees the GP's treatment plan in the comprehensive patient record. This level of timely coordination and intervention helps prevent a hospital admission for Beth. Both the cardiologist and the GP incorporate the aggregated data into their reporting and analytics initiatives to improve quality and qualify for incentives.*

