CLINICAL POPULATION MANAGEMENT:
What is it and why does chronic disease care need it?

LET'S START WITH AN ANALOGY.

In the early days of aviation "air traffic control" amounted to a person standing on a runway waving a couple of signal flags when they spotted an incoming plane. Imagine a busy airport trying to operate that way today. Minus the capacity to track and manage all air traffic simultaneously, interminable problems would abound – from relentless backups and delays to catastrophic crashes and collisions. Absolutely no one would defend this is a safe, practical, or sustainable way to run a modern day airport. The volume of traffic is too great, the technology too advanced, and the stakes too high for yesteryear's intermittent, one-plane-at-a-time approach to air traffic control.

Likewise, in chronic disease care the time has passed for the customary patient-by-patient, visit-dependent approach to clinical care. Growing patient panels, along with incredible advances in medical technology and treatments, have rendered this system of care impractical, unsustainable, and even unsafe insofar as it makes optimal care virtually impossible to achieve. Yet most chronic disease specialists continue attending to patients solely at the individual level, meaning at the time the patient shows up for an office visit and, for the most part, mainly within the context of this visit.

Then, like departing planes that disappear on the horizon, patients leave the office and fall out of view. In fact, if they don't take the initiative to schedule a next visit, they can easily be lost to care. And even if they do make another appointment, in many busy practices a lack of available visit slots can push the visit months later than it should be. As a result, gaps in patient care have become endemic across chronic disease care – gaps that physicians can't even see within the customary systems of care.

THE ANSWER IS IN "PLANE" SIGHT.

It's important to understand that these gaps are *not* the fault of physicians or their care teams; they have nothing to do with competence or professionalism. They're simply an inevitable result of conventional systems of care that have failed to keep pace with ever-expanding patient panels and an explosion of advances in chronic disease assessment and treatment. The field of chronic disease care is in dire need of an upgrade to its own modern "air traffic control" system that enables practice teams to "see" every patient concurrently in real time, and thus coordinate the care of an entire disease population simultaneously.

Fortunately, that upgrade already exists. It's called *clinical population management*, and chronic disease specialists are beginning to implement it with impressive results. It involves using a simple database (of the physician's choosing; an EMR doesn't have this functionality) to consistently track one or more disease activity scores across an entire disease population. Using this collective data, which takes minimal time and effort to accrue, practice teams are able to:

- continuously and concurrently monitor the care and wellbeing of all their patients;
- assure on-time disease assessment across a patient disease population;
- tailor care protocols based on patients' disease activity levels, disease duration, and prognosis; and
- vastly improve practice workflows to maximize use of staff skills and increase patient visit capacity.

Clinical population management also gives clinicians the capability to document improvements in outcomes across a patient population over time – a necessary function in light of forthcoming Medicare mandates.

In today's healthcare environment, traditional systems of chronic disease care no longer get the job done. Clinical population management is necessary to achieve and document the best possible care and outcomes, both individually and across the chronic disease spectrum.

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