VBP/VBC Domain – Population Health & Care Management

DESCRIPTION

Population health is the idea of moving our focus from individual health to the health of a group of individuals. Relevant to the current goals of VBP (value-based pay) models, as primary care shifts its focus from individual patients to population health management, we can better address health disparities in the communities we serve. In order to do this effectively, we need to address the comprehensive needs of the patients we serve, including medical, behavioral health, oral health, and social drivers of health (SDoH).

Population health has been defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire human population. It has been described as consisting of three components. These are "health outcomes, patterns of health determinants, and policies and interventions." (Wikipedia)

Population health management is an approach to primary health care provision that integrates active outreach and engagement with the community in care delivery. This approach shifts primary care service delivery from reactive to proactive management of a segment of the population. It requires a strong organizational structure, efficient information systems, and an appropriate mix and sufficient quantity of providers. Inherent in population health management is the provision of a broad range of health activities, including curative and preventive care, health promotion activities delivered through broad public health initiatives, and engagement with SDoH. (Primary Health Care Performance Initiative).

According to InfoMC, care management is a collaborative approach to healthcare that focuses on coordinating and managing the care of individuals to ensure that individuals receive the right care, at the right time, in the most appropriate setting. By personalizing a plan of care according to each individual's needs, care management enhances the quality of care, improves health outcomes, and optimizes the use of healthcare resources, particularly for individuals with complex medical needs.

Care management is also a strategy that is employed to manage the health of populations. The Agency for Healthcare Research and Quality (AHRQ) developed a care management issue brief in 2015 (when care management emerged as a leading strategy for managing population health) and revised the brief in 2018. The brief identified 3 key care management strategies informed by the experience of AHRQ grantees – identify populations with identifiable risks, align care management services to the needs of the population, identify and train personnel appropriate for the need of care management services.

Capabilities for population health and care management include identifying the risk level of each patient and addressing their needs. It's not just about providing acute care to patients with chronic conditions; prevention and planned care are important to this domain for all HC patients. HCs should be reaching out to patients who aren't accessing HC services to close care gaps and provide appropriate prevention services.

As payment reform moves from fee-for-service (FFS) to value-based pay (VBP), population health management becomes more important as providers are held accountable to cost, quality, and access metrics for a group of assigned patients. Key areas of focus for population health management include:

- Implementing patient-centered, team-based care.
- Providing comprehensive care that addresses the medical, dental, behavioral health, and SDoH needs of patients.
- Integrating medical, behavioral health, oral health, and SDoH interventions.

- Improving access to care.
- Providing care management and care coordination.
- Optimizing health information technology to support better care.
- Providing data analytics at the provider team level, including stratifying patients into high risk, rising risk, and low risk patients.

RATING YOUR HC LOW, MEDIUM, OR HIGH FOR THIS DOMAIN

Attributes of HCs that are rated low, medium, or high for capabilities in this domain:

1. The health center has experience managing care for groups of patients and/or populations with chronic conditions (*from Delta Center's MAHP 2.0 Assessment)*.
    a. Low – The health center identifies high-risk patients informally or through chart review. Health center has implemented a HRSA sponsored or similar disease collaborative at a minimum of one site.
    b. Medium – Disease registries are used to categorize subpopulations by clinical priorities. All service delivery sites participate in disease collaboratives. Lessons learned and best practices are shared across the organization. Specific disease conditions are included in continuous quality improvement (CQI) efforts on an ongoing basis.
    c. High – The health center engages in regular and continuous management of patient visits for specific chronic conditions. The model of care includes systematic preventive, follow-up and planned visits for chronic care.
2. The health center has experience managing high utilizer/high cost patients. (*Delta Center's MAHP 2.0 Assessment).*
    a. Low – The health center has not engaged in specific initiatives for high-utilizer/high cost patients. The health center systematically identifies its own patients who are high utilizers of health center and/or system resources.
    b. Medium – The health center participates in Managed Care Organization (MCO) or hospital initiatives to address inappropriate utilization and prevent hospital re-admissions or admissions for ambulatory care sensitive conditions.
    c. High - The health center has a contract with an ACO or MCO to conduct care management/coordination for its own high utilizer patients. Health center has a contract with an ACO/MCO to provide care management/ coordination for high utilizer patients in the service area, beyond its own patients.
3. The health center coordinates and manages care throughout the delivery system (NACHC Payment Reform Readiness Assessment Tool).
    a. Low – The health center focuses primarily on obtaining specialty, behavioral health, substance use disorders, and hospital care for patients needing follow-up care. Health center has referral relationships with community organizations addressing social drivers of health. Referrals are made and tracked, but there is not a system for determining whether referral is successfully completed.
    b. Medium – The health center has established processes for establishing patient-driven care plans and ongoing follow-up and patient support for the plan, using motivational interviewing or other techniques. Health center has referral tracking and follow-up systems and a workforce with the ability to support those systems. Health center uses health coaches/community health workers to support care coordination among other providers such as specialists and hospitals, as well as other sources of support such as organizations addressing SDoH.
    c. High – The health center care teams have the flexibility to coordinate with community services, particularly those addressing SDoH. Health center staff has the ability and systems needed to provide patients with a seamless care experience, coordinating health and social services addressing patients' preventive, primary care, oral health, pharmacy, vision, behavioral health and substance use disorder needs. Health center

contracts with ACO/managed care organization to provide care management/coordination for high utilizer patients in the service area, beyond its own patients.

4. The health center's health information technology (HIT) systems allow for use of internal and external data to support population health management. (*NACHC Payment Reform Readiness Assessment Tool)*).
    a. Low – The health center participates in some population-wide, information exchange networks such as those related to IPAs, MCOs, and/or health information exchanges.
    b. Medium – The health center uses data exchanged via the information exchange networks to inform service model and payment transformation efforts.
    c. High – Robust health information exchanges allow the health center to exchange data with other care providers and payers in real time. Information exchange networks collectively assess aggregate data to address health disparities, support value/return on investment studies and inform other policy, payment, and system-wide transformation efforts to improve population health while reducing the total cost of care.

If you are interested in your HC taking a more comprehensive VBP assessment, below are some options:

- Delta Center's MAHP 2.0 Assessment Tool https://deltacenter.jsi.com/resources/road-ahead-model-advancing-high-performance-primary-care-and-behavioral-health-under
- NACHC Payment Reform Readiness Assessment Tool https://www.nachc.org/resource/payment-reform-readiness-assessment-tool/

RESOURCES FOR CHCS TO IMPROVE THIS CAPABILITY

LPCA, HCCN and/or LPCACO programs/support:

- LPCA provides education on CMS VBP initiatives focused on value-based transformation and population health.
- LPCA will support HCs in completing VBP/VBC self-assessments through these Domain communication tools and by informing HCs of other tools and resources.
- LPCA, LPCACO programs to support team-based care engagement: Azara DRVS Trainings (Referral Management, Risk Assessment, SDOH, Transitions of Care), Remote Patient Monitoring, PRAPARE

Other partners that can help CHCs improve this capability:

- *PCA Value-Based Care Collaborative and Online Resources*
- *NACHC Populations Health and PCMH Online Resources and Conferences (CHI, FOM/IT, Peer Learning, etc.)*
- *NACHC Elevate program that has a focus on population health and care management*
- *JSI/Delta Center For A Thriving Safety Net*
- *Institute of Medicine resources*
- *National Committee of Quality Assurance resources*

Links to resources for this capability:

Population Health:

- NACHC resources for improving population health management: https://www.nachc.org/clinical-matters/value-transformation-framework/#care
- NACHC population health management action guide: https://www.nachc.org/wp-content/uploads/2023/04/NACHC-VTF-Pop-Health_Models-of-Care-AG_November-2019.pdf
- Institute for Healthcare Improvement (IHI) resources for improving population health: https://www.ihi.org/Topics/Population-Health/Pages/Resources.aspx
- NCQA population health accreditation: https://www.ncqa.org/programs/health-plans/population-health-program-accreditation/

- Health Affairs article on the importance of primary care to population health and health equity: https://www.healthaffairs.org/content/forefront/primary-care-investment-key-improving-population-health-and-reducing-disparities
- AMA blog on what is meant by population health and why it matters to physicians: https://www.ama-assn.org/delivering-care/population-care/what-meant-population-health-and-why-it-matters
- Population health management roadmap: https://www.pcpcc.org/sites/default/files/resources/PHM-IBM_Watson-RR.pdf

Care Management:

- AHRQ issue brief on care management https://www.ahrq.gov/ncepcr/care/coordination/mgmt.html
- NACHC Value Transformation Framework Action Guide – Care Management https://www.nachc.org/wp-content/uploads/2022/01/Care-Management-AG_December-2021.pdf
- NACHC reimbursement tips for Medicare transitional care management https://www.nachc.org/wp-content/uploads/2022/06/Reimbursement-Tips_TCM_May-2022.pdf
- NACHC reimbursement tips for Medicare chronic care management https://www.nachc.org/wp-content/uploads/2022/06/Reimbursement-Tips_CCM_CCCM_PCM_May-2022.pdf
- CMS care management resources https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/care-management
- What is care management https://www.infomc.com/what-is-care-management/
- Aledade transitional care management white paper https://resources.aledade.com/white-papers/transitional-care-management-how-acos-are-getting-patients-into-the-doctors-office-and-out-of-the-hospital
- CHCS care management framework https://www.chcs.org/media/Care_Management_Framework.pdf

Other Resources that Include Population Health and Care Management:

- CMS Innovations Center https://innovation.cms.gov
- The Delta Center Model for Advancing High Performance in Primary Care and Behavioral Health Under Value-Based Payment Delta Center.JSI Resources
- NASEM implementing high quality primary care https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care