NATIONAL ASSOCIATION OF Community Health Centers

Population Health Management

Background

There is a general consensus around the need to focus on healthier people and communities, and better and more affordable healthcare (the "Triple Aim"). Defining population health is a first step toward creating systems that effectively manage the health of a population.

This document defines population health and population health management and provides a conceptual framework health centers can apply in moving forward toward Population Health Management (PHM).

The National Association of Community Health Centers (NACHC) embraces the definition of population health put forth by the National Quality Forum (NQF) as 'the health of a population, including the distribution of health outcomes and disparities in the population.'[1] Population health in this framework is focused on the group of individuals within a specific geopolitical area and recognizes that the health of a population is more than just the clinical aspects of care and includes social, economic, environmental, and individual behavioral and genetic traits. PHM, on the other hand, is the management of health and outcomes for subpopulations such as the population of patients served by a health center. This effort is frequently referred to in more recent literature as population medicine. The Institute for Healthcare Improvement defines population medicine as the 'design, delivery, coordination, and payment of high-quality health care services to manage the "Triple Aim" for a population using the best resources we have available to us within the health care system.'[2]

Health Center: Call To Action

As health centers embark on a journey to achieve the "Triple Aim", they need to determine to whom they hold themselves accountable. Given the health care system is a long way from having health information combined with information from such sources as social service agencies, police records, air and water quality, real estate foreclosures, and other data that might provide insights into groups of individuals with social risks that pose threats to health outcomes, where do health centers begin meaningful work toward population health? This journey can begin with PHM, or population medicine, and a health center's focus on achieving the "Triple Aim" among its population of patients.

[1] National Quality Forum. Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities – Action Guide 3.0. May 2016 DRAFT.

[2] Niñon Lewis. "Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in US Health Care Today." *IHI Leadership Blog*. 19 March 2014.

Action Steps Toward Population Health Management

As health centers develop new care delivery structures, broadened collaborations, new payer arrangements, and expanded IT and data capabilities, certain foundational activities will be required in the path toward population health management. While there is no set framework for success, NACHC supports development in each of the below actions as critical components in a successful Population Health Management (PHM) approach to the "Triple Aim".

1 Patient Centered Medical Home (PCMH) Recognition

PCMH Recognition demonstrates core capability in creating a system of care upon which the health and outcomes of a population can be effectively managed and patients can be more actively engaged.

2 Patient Registry

Health centers need to maintain a patient registry that goes beyond the list of current patients and includes all patients attributed to a practice. The patient registry should include, at a minimum, clinical and administrative data, including lab, pharmacy, procedure codes, and diagnostic and screening results. Over time, this system should include, or link to, claims data.

3 Accountable Care

Each patient in the health center registry needs to be linked to a primary care provider or care team who is accountable for organizing and delivering the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors.

4 Risk-stratification

The unique population served by health centers necessitates stratification of patients based not only upon complex medical conditions but also social determinants of health affecting outcomes. Minimally, a health center can begin with a simple stratification algorithm (multiple chronic conditions) but should move toward a risk stratification process that accounts for social determinants of health.

5 Annual Health Screenings

Improving upon clinical measures and preventive screenings requires a system of care designed to accomplish these tasks. Health centers need to design care processes that schedule patients for an annual health screening that incorporates all recommended preventive screenings and an assessment for social risk. This process can be rolled out over time, depending on patient population size, and should begin with high-risk patients.

6 Redeploy Staff in Support of Population Health Management

Develop care teams in new ways that coordinate care, link to social services, and proactively manage (communication with high-risk patients at least every 90 days) whole person care.

7 Use Data to Manage Patient Populations

Use dashboards and other tools to monitor the health of each provider's panel and the population as a whole.

8 Health/Community System Partnerships and Communication

Build partnerships and effective communication channels with health system entities (hospitals, specialists, public health agencies), IT (networks, HIE), and social service organizations (housing food, transportation) including sharing referrals and outcomes. Include mechanisms for patients to engage in communication and care processes.

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