NATIONAL ASSOCIATION OF Community Health Centers

Understanding Population Health Management

What Governing Boards Need to Know

Board members play an important role in improving the way patients are cared for in the health center. As a board member, you want to see:

- High quality patient care
- Lower health center costs
- Better clinical/health results

These three goals are called the "Triple Aim".

Some people add a fourth goal:

- Better provider satisfaction

These four goals together are called the "Quadruple Aim".

You can help your health center reach these goals with Population Health Management (PHM) tools. PHM offers better ways to deliver care, improve health outcomes, and lower health center costs.

What is Population Health Management?

Population Health is a term used to talk about the health status of groups of people in your community. It tracks people over time, grouped (for example) by disease, care costs, and how happy they are with their care. High-risk patients are most likely to be hospitalized, use the emergency room, and need high-cost care.

Population Health Management focuses on what is done to help groups of patients reach better health outcomes. When health center staff work together to provide more coordinated services, they see better results. This is most important for high-risk patients and the people who need more care and support than others.

When health centers can track and treat high-risk patients, they can see success. This is how value-based care is provided. Many health centers (over 75% of them) already use PHM strategies as Patient Centered Medical Homes (PCMHs). The PCMH model uses these ideas to improve the way they provide care.

5 Core Concepts of PHM

1 Patient-Centered Access

Easier access to doctors and health center staff. Appointments and information are accessible for patients (early and late hours, phone question and answer services, text reminders, and patient portals.)

2 Team-Based Care

Groups of providers work together to improve care for patients. A full range of services can be offered to address patient needs.

3 Care Management

Extra attention is paid to the sickest and highest-risk patients, so they get the care they need, when they need it.

4 Care Coordination

Health center staff work with partners (like emergency rooms, counselors, pharmacies, and others) to support the health of high-risk patients.

5 Quality Improvement (QI)/ Performance Measurement

Measures are put in place to see how close the health center is to reaching their "Triple/ Quadruple Aim" goals.

Board Member Call to Action

As a board member, it is important to support policies and practices that lead to success. Here are some questions to ask your health center leadership about PHM practices:

1 Patient-Centered Access

- How can the health center improve scheduling appointments for doctors to see more patients, and increase revenue? (Can appointment schedules match when most patients want to come?)
- What does the health center do to prevent "no-shows"?
- What IT investments should be made to track the use of services and improve access to services offered at the health center?
- Does the health center offer services like follow-up phone calls, patient portals, or a hotline for nursing questions? Text reminders? If not, can it?
- Do patients get access to (or referrals to) a full range of services, including substance abuse counseling, a pharmacy, or OB/GYN care at the health center or nearby?

2 Team-Based Care

- Can the health center create and use care teams that include Health Educators, Care Coordinators, and Behavioral Health Specialists (experts who can teach patients self-care skills)?
- Will team-based care help with physician recruitment and retention, and increase the number of patients each physician can see?
- Can clinical staff practice to the full scope of their licensure?
- Are team members used efficiently? (pharmacists for medication management, health educators for self-care information, RNs between visits)
- What training would offer team members coaching on how to work best as a team, to see more patients, and to prevent unnecessary services?

3 Care Management

- Can our IT systems assign risk to patients for care management? Or do we have PHM software to help us learn who is a "high-risk patient"? If not, what software or training should the health center invest in?
- Does the health center have the right staff in place to provide care management services to high-risk patients?
- How can the health center help patients stick to their care plans? (Can child care, transportation, or financial support services be offered?)

4 Care Coordination

- Can the health center share information electronically with partners?
- Can I help build relationships with area service providers to share information?
- Does the health center need to invest in more clinical support staff to take on the responsibility of Care Coordination?

5 QI/Performance Measurement

- Are the health center's QI goals aligned with the "Triple/Quadruple Aim"?
- What performance measures (cancer screenings, appropriate immunizations) does the health center use?
- Can the electronic tracking systems offer reports that will help us with PHM?
- Does the health center need to invest more in QI resources?
- Would it help to hire an external coach to assist with QI goals and performance measures?