NATIONAL ASSOCIATION OF Community Health Centers

Population Health Management: **Care Management**

Care Management is a way to provide extra attention to the sickest and highest-risk patients, with an eye for the whole patient and their wellbeing. High-risk patients are identified by socio-economic factors (housing, food security), health status (drug use, AIDS, diabetes, etc.), language, service use, and other factors.

Health centers are using Care Management as one Population Health Management (PHM) strategy to achieve the "Quadruple Aim" — improved patient experiences, improved clinical outcomes, and lowered costs while also improving the work life of health care providers.

Population Health Management (PHM) is a *"set of interventions that can improve people's health across the full continuum of care…"* (Felt-Lisk, S. & Higgins, T.)

The 5 Core Concepts of PHM are:

1. Patient-Centered Access
2. Team-Based Care
3. **Care Management**
4. Care Coordination
5. Quality Improvement/Performance Measurement

Care Management is a way to work more closely with patients to help them get the care they need: phoning or texting reminders to refill a prescription or get follow-up care, offering transportation, aligning treatment plans, discussing plans to prevent future emergency room visits, and employing other strategies to involve patients in their own care. Care Management is aligned with Care Coordination, which involves coordinating a patient's care along a full range of external community resources and providers, as needed. Both Care Management and Care Coordination are important functions of the expanded care team approach used in PHM.

The first step to improving Care Management for high-risk patients is identifying which patients have uncontrolled health needs and why. Answer these questions:

- Which patients could benefit from Care Management? Can our Electronic Health Records (EHR) identify high-risk patients?
- Why are these cases uncontrolled? What can change in the way these patients receive care?
- What interventions (between visits) will ensure that the patient receives the care they need?
- What strategies should be used to engage the patient in better self-care?
- What tools should we use to track and manage each patient's care?

Key Population Health Management Tools for Care Management

The **NCQA Patient Centered Medical Home Standards and Guidelines (2014)** help define populations for Care Management based on these and other factors:

- Behavioral health conditions
- High cost/high utilization
- Poorly controlled or complex conditions
- Social determinants of health
- Referrals by outside organizations (insurers, health system, ACO), practice staff or patient/family/caregiver

Use your **EHR, Patient Registries** or **PHM software** to identify patients who need Care Management:

- Target patients based on their health risk, service use, and other socio-economic factors
- Use EHR or PHM software to track each patient's service use
- Use PHM software programs such as i2i Tracks/PopIQ, Azara DRVS, and Acuere QOL to create patient registries and plan care

Use **Motivational Interviews** or other patient communication skills to **encourage patient engagement**

- Care Management is successful over time when the care team can engage patients and keep them engaged with their own self-care and wellbeing
- Training care teams in **Motivational Interviewing** skills to drive self-care and self-management is often helpful. Patients can and should be involved in overcoming their own barriers to care

Create **Care Need Reports**. These reports identify missed or soon to be overdue care needs, with a calendar tickler system.

Assess community resources so you can **provide the best referrals possible**

- Establish partnerships or referral relationships with community resources
- Check community resource manuals and reviews. Offer patient surveys to gain feedback on community resources (like a local cessation or drug addiction hotline, a dietician, or mental health counselor)

Measures of Success*:

1. Percent of patients identified and monitored for Care Management services
2. Percent of patients who receive the targeted care, medication or service they need
3. Percent of patients who are actively engaged in their own Care Management
4. Percent of referrals made to valued community resources (based on patient surveys)

**Targets are situational. Please refer to the 2014 PCMH Recognition Standards and Guidelines.*

National Association of Community Health Centers
7501 Wisconsin Ave, Suite 1100W | Bethesda, MD 20814 | 301-347-0400 | www.nachc.org
NACHC | nachc | nachcmedia | nachc | nachc-hc-news