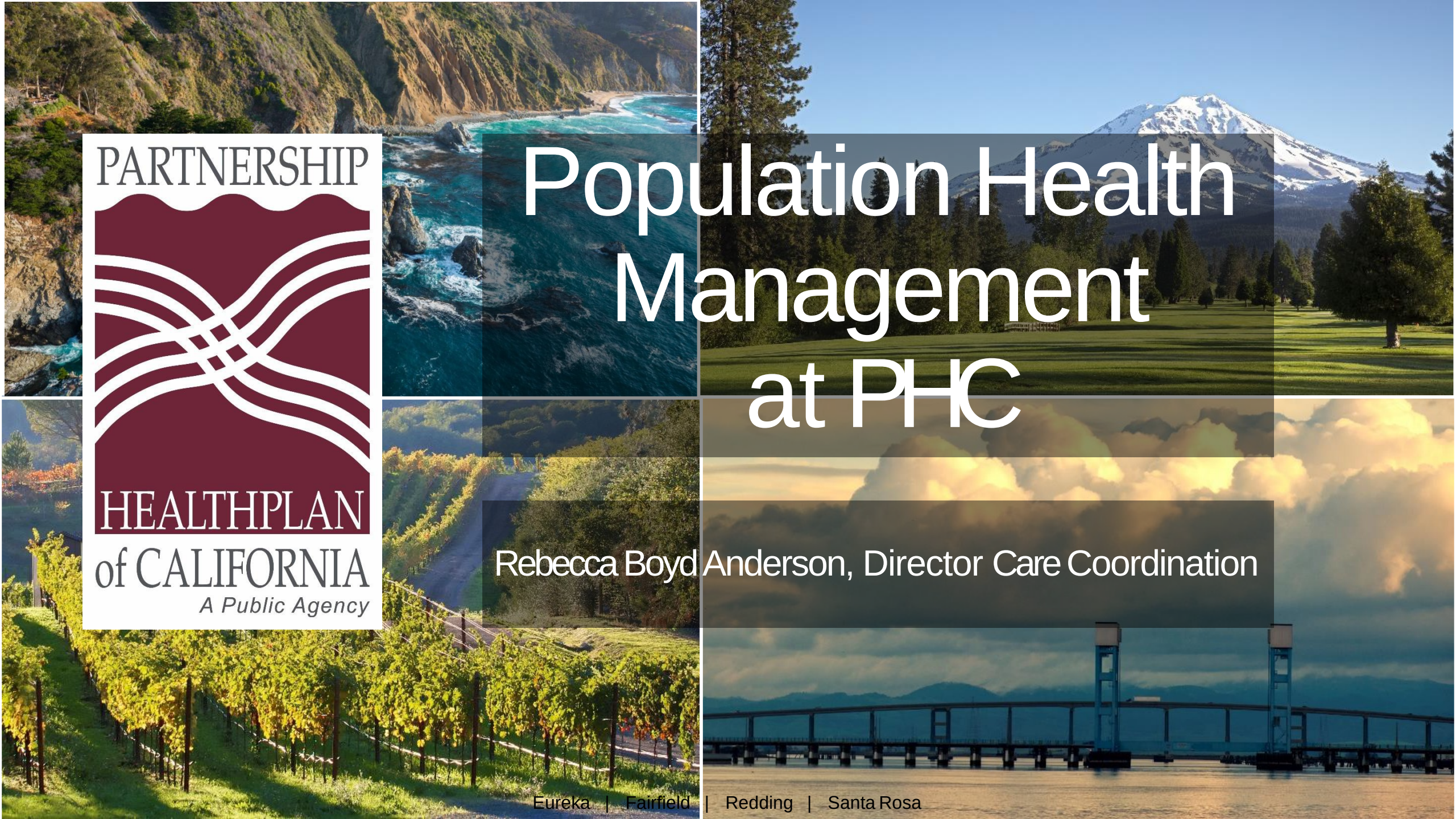

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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Population Health Management at PHC

Rebecca Boyd Anderson, Director Care Coordination

What is Population Health Management (PHM)?

- How we promote the health and wellbeing of the communities we serve
- Includes:
  - Assessing the population
  - Segmenting the population
  - Developing/targeting activities to meet needs of the population
  - Analyzing the results and continuously improving interventions
- Involves collaboration across all sectors
  - Health Plan
  - Providers
  - Counties
  - Community-Based-Organizations
  - Members
- An NCQA requirement

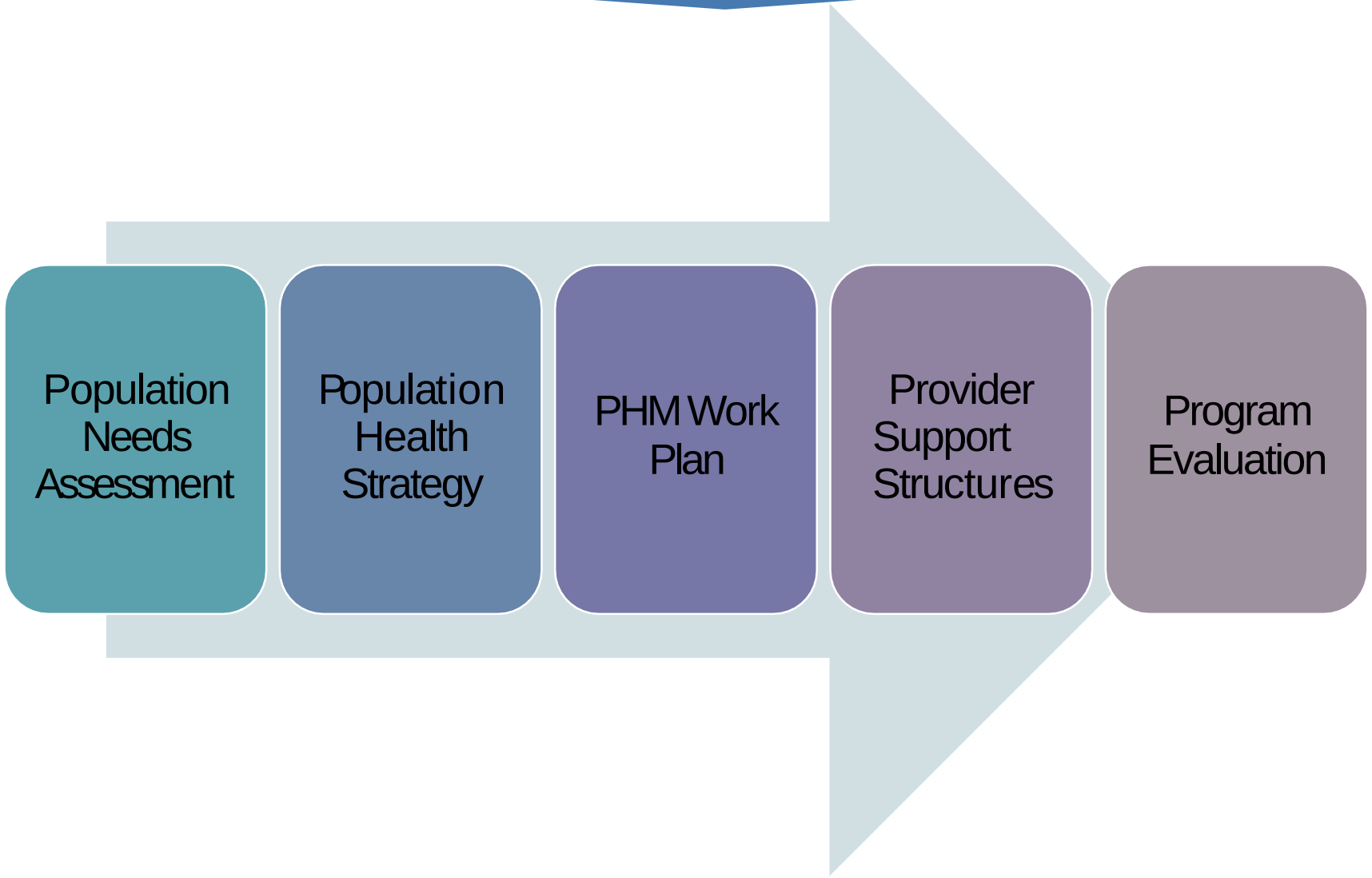
Definition of Population Health Management

Intentional and proactive organization of care that utilizes:

- actionable data & information technology,
- collaborative teams, and
- clear goals

to improve heath outcomes for defined populations for whom the organization is accountable for cost and quality of care.

PHC's Approach to PHM



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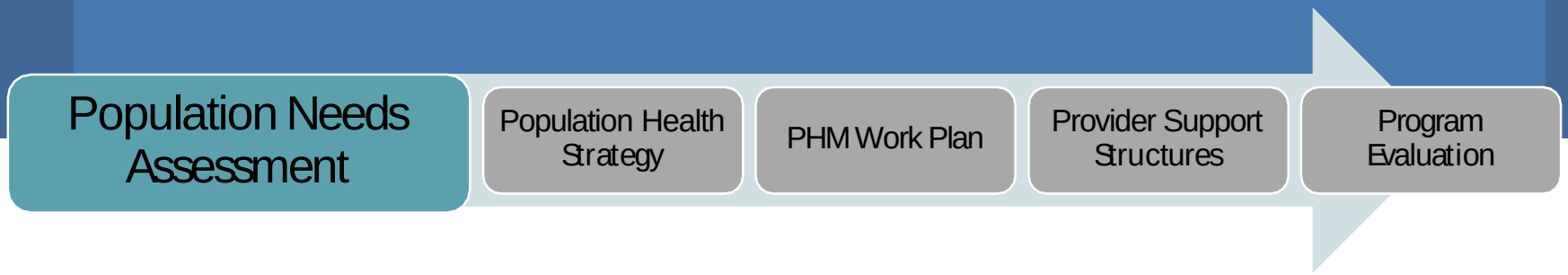

Annual Data-Driven Analysis of PHC's Regions and Members Performed by Health Education Team & Health Analytics Drives Interventions and Programs

- Communications
- Health Education
- Quality
- Care Coordination
- Provider Relations
- Initiatives
  - Housing Grant
  - Drug Medi-Cal

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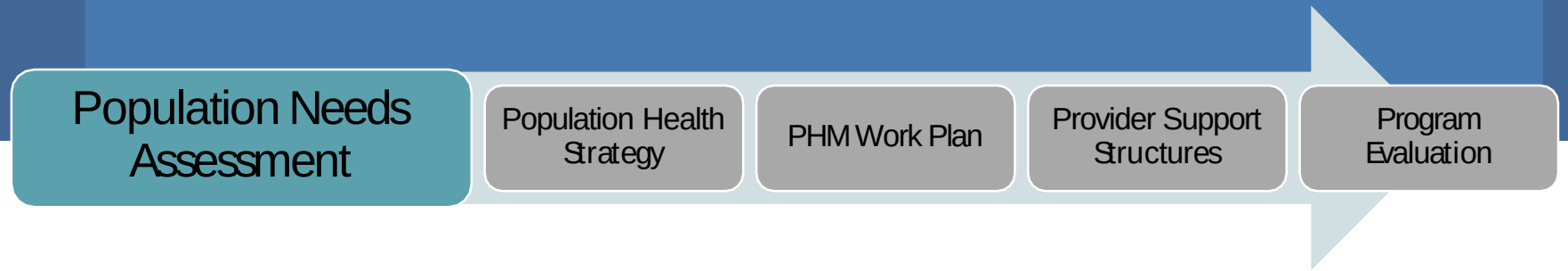

Data Sources

- Health plan data
  - Member demographics
  - Medical and pharmacy claims
  - Disease registries
  - Transportation claims
- CMS adult and child core sets
- Consumer and Assessment of Healthcare Providers and Systems (CAHPS)
- Focus Group / Member Interviews
- County Data
- Provider Community Needs Assessment
- Social Determinants of Health
  - California Healthy Places Index
  - County Health Rankings State Report

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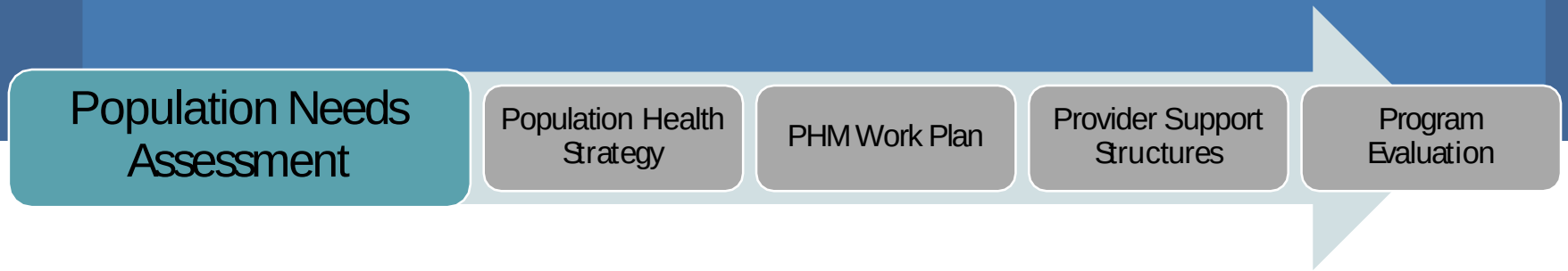

Key Findings

- Social / Environmental Issues for PHC Members
  - Children living in poverty
  - Violent crime and injury deaths
  - Food insecurity
- Health Behaviors
  - Adult smoking
  - Impaired driving
  - Substance use disorder
- Vulnerable Populations
  - CCS/ Children and Youth with Special Health Care Needs
  - Seniors and Persons with Disabilities
  - Homeless
  - Serious and Persistent Mental Illness
  - LGBTQ+

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Population Needs Assessment | **Population Health Strategy** | PHM Work Plan | Provider Support Structures | Program Evaluation

Integrate Population Needs into PHC's Strategy

- Keeping Members Healthy
- Managing Members with Emerging Risk
- Outcomes Across Settings
- Managing Multiple Chronic Conditions

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Population Needs Assessment | **Population Health Strategy** | PHM Work Plan | Provider Support Structures | Program Evaluation

Segmenting Member Needs

Keeping Members Healthy

- Primary & Preventative Care
- Explanation of Benefits
- Health Education
- Community Activities

Managing Members with Emerging Risk

- Chronic Care
- Health Coaching
- Behavioral Health Support
- Community Support Groups

Outcomes Across Settings

- Acute Care
- Support through Transition
- Discharge Education
- End of Life Care
- Community Resources

Managing Multiple Chronic Conditions

- Complex Care
- Individualized Care Plan
- County Mental Health
- Robust Social Supports
- Community Structures

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Population Needs Assessment | Population Health Strategy | **PHM Work Plan** | Provider Support Structures | Program Evaluation

Aligning Services with Member Needs

Keeping Members Healthy

- Low-Risk New Member Assessments
- HEDIS Outreach Calls
- Growing Together Well-Baby Program
- Care Coordination Access to Care
- Birthday Club

Managing Members with Emerging Risk

- Growing Together Maternal Program
- Pharmacy Point of Sale Messages
- Mild/Moderate Mental Health Case Management

Outcomes Across Settings

- High-Risk Infant Follow Up
- Utilization Management Discharge Planning
- Care Coordination Transitions of Care Program

Managing Multiple Chronic Conditions

- High-Risk New Member Assessments
- Care Coordination Complex Case Management
- Integrated Behavioral / Medical Complex Case Management

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Identifying Cases

Keeping Members Healthy

- Health Information Forms (HIFs)
- Member Self-Identification
- Annual CCS-Member Re-assessments
- HEDIS Well-Care Gap Lists
- Newborn Delivery Reports

Managing Members with Emerging Risk

- HEDIS Chronic Disease Gap Lists
- Pregnancy / Delivery Reports
- Medication Fill Reports
- Disease Registry Reports
- Change in Utilization Reports
- Provider Referral

Outcomes Across Settings

- Hospital Discharge Reports
  - High-Risk Infant
  - Pediatric Discharge
  - Adult Discharge Home
- Utilization Management Referral
- Provider Referral

Managing Multiple Chronic Conditions

- High Utilizer Report
- New CCS Condition Report
- Provider Referral
- County Partner Referral
- Member/Caregiver Self- Referral
- Other Care Coordination Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

Population Needs Assessment | Population Health Strategy | PHM Work Plan | **Provider Support Structures** | Program Evaluation

Sharing Data

- eReports
  - Provider measures targeted for incentive
- Partnership Quality Dashboard
  - HEDIS measure-specific data for provider's paneled members
  - Trended data (monthly or annually)
- Comparable Data
  - Peer performance, local averages, and national benchmarks

Practice Transformation Technical Assistance

- ABCs of QI
- ADVANCE training program

Value-Based Payment Programs

Ongoing Education / Support

- Provider Newsletters & Education
- Annual Conference

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

Population Needs Assessment | Population Health Strategy | PHM Work Plan | Provider Support Structures | **Program Evaluation**

Outcomes Data

- HEDIS performance measure data for targeted measures
- Complex Case Management Outcomes
  - Emergency Department Visits
  - Inpatient Admissions
  - Total Inpatient Days
- Transitions of Care Outcomes
  - PCP visit within 28 days of discharge
  - 90 day readmission rate
- Member Experience Surveys
  - Complex Case Management
  - Transitions of Care

Population Needs (re)-Assessment

Summary

PHC's Mission Statement is

"To help our members,

and the communities we serve,

be healthy"

=

Population Health