Provider Focus: Population Health Management

Learn more about our Gathering Member Info (GMI), Understanding Risk, and Providing Services & Supports (PSS) / PHM Programs

Our Family of Brands

health net

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Health Plans We Support

Goals

- Share our PHM Overview for our Providers to understand more about our GMI, RSST, and PSS/PHM work
- Define clear roles and responsibilities related to GMI, RSST, PSS/PHM work
- Provide clear expectations on screenings and assessments
- Reinforce the DHCS/Health Net expectations

PHM Policy Guide – August 2023

What Is the PHM Program?

The PHM Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. Specifically, the PHM Program intends to:

- **Build trust with and meaningfully engage members**
- **Gather, share, and assess timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes**
- **Address upstream drivers of health through integration with public health and social services**
- **Support all members in staying healthy**
- **Provide care management services for members at higher risk of poor outcomes**
- **Provide transitional care services (TCS) for members transferring from one setting or level of care to another**
- **Reduce health disparities**
- **Identify and mitigates Social Drivers of Health (SDOH)**

The launch of the PHM Program is part of a broader arc of change to improve health outcomes that is further articulated in DHCS' Comprehensive Quality Strategy (CQS), which emphasizes the long-lasting impact of coupling quality and health equity efforts with prevention. Under the PHM Program, MCPs and their networks and partners will be responsive to individual member needs within the communities they serve while working within a common framework and set of expectations. While the PHM Program is a statewide endeavor that interacts with other delivery systems and carved-out services and requires meaningful engagement and partnerships with members and other stakeholders, the requirements outlined in the PHM Policy Guide apply specifically to MCPs.

DHCS PHM Policy Guide – August Update

Our integrated approach to provide well-rounded and seamless care

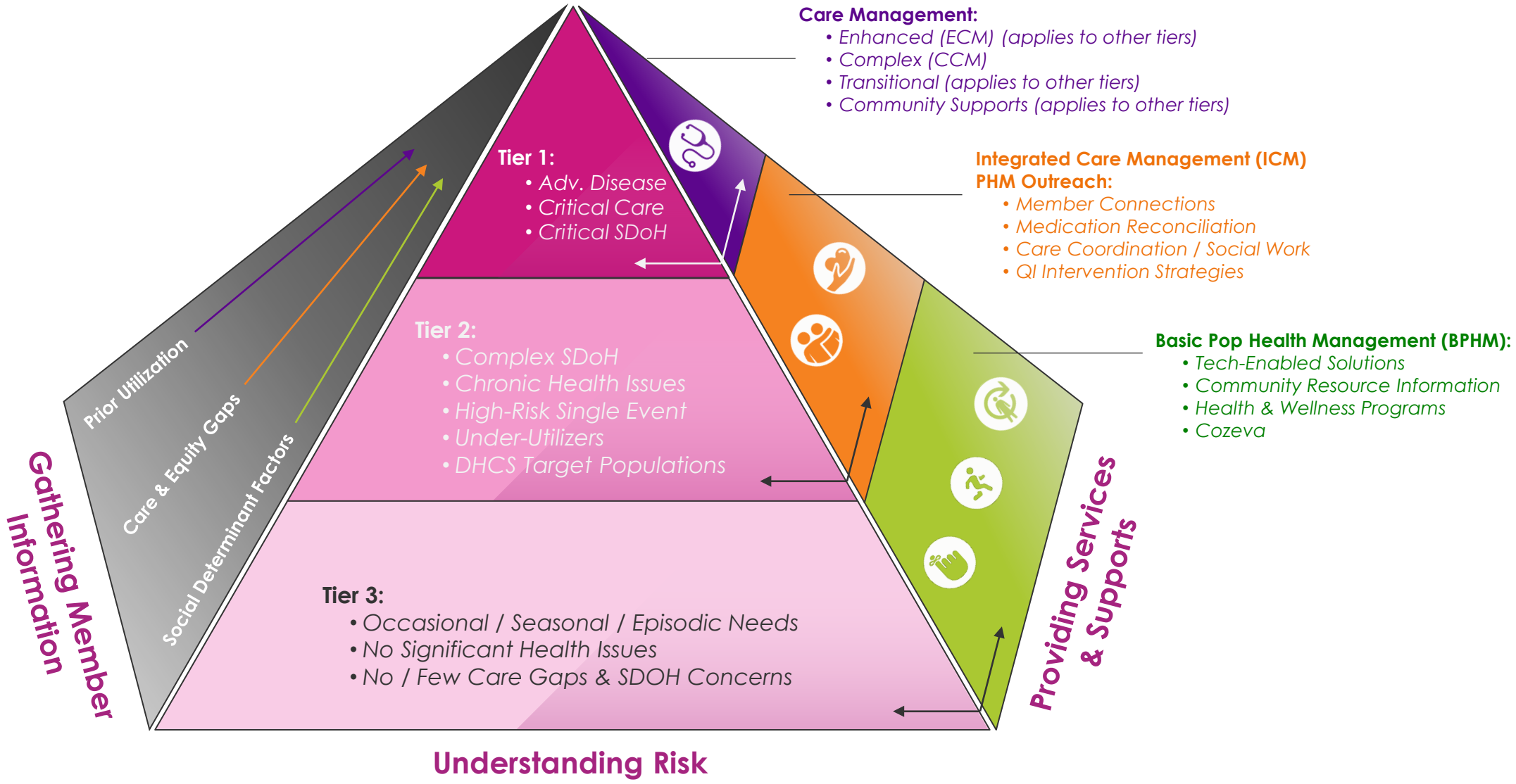
All Stages of Life

- Newborn/infants
- Children
- Young adult
- Pregnant member
- Adult
- Seniors
- Single event/condition
- Multiple chronic conditions
- Severe illness
- Palliative / hospice

With a Focus on Equity

- Housing/Food
- Safety/security
- Transportation
- Justice Involved
- Foster Care
- Health literacy
- Interpreter/translation/ language
- Financial/socioeconomic
- Cultural/social/familial
- LGBTQIA+
- Rural/access deserts
- Homebound/disabilities

Our 3D PHM Model



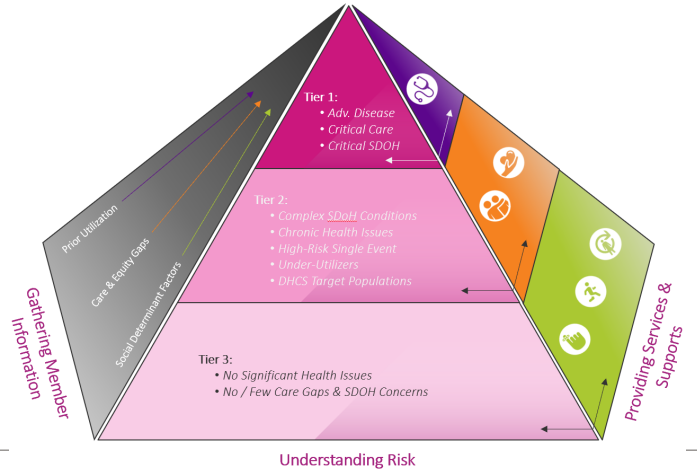
High level visual

1

Gather member information (screening, assessment, social, physical, behavioral, quality data)

2

Inform Risk Stratification, Segmentation, Tiering (RSST) in Pyramid



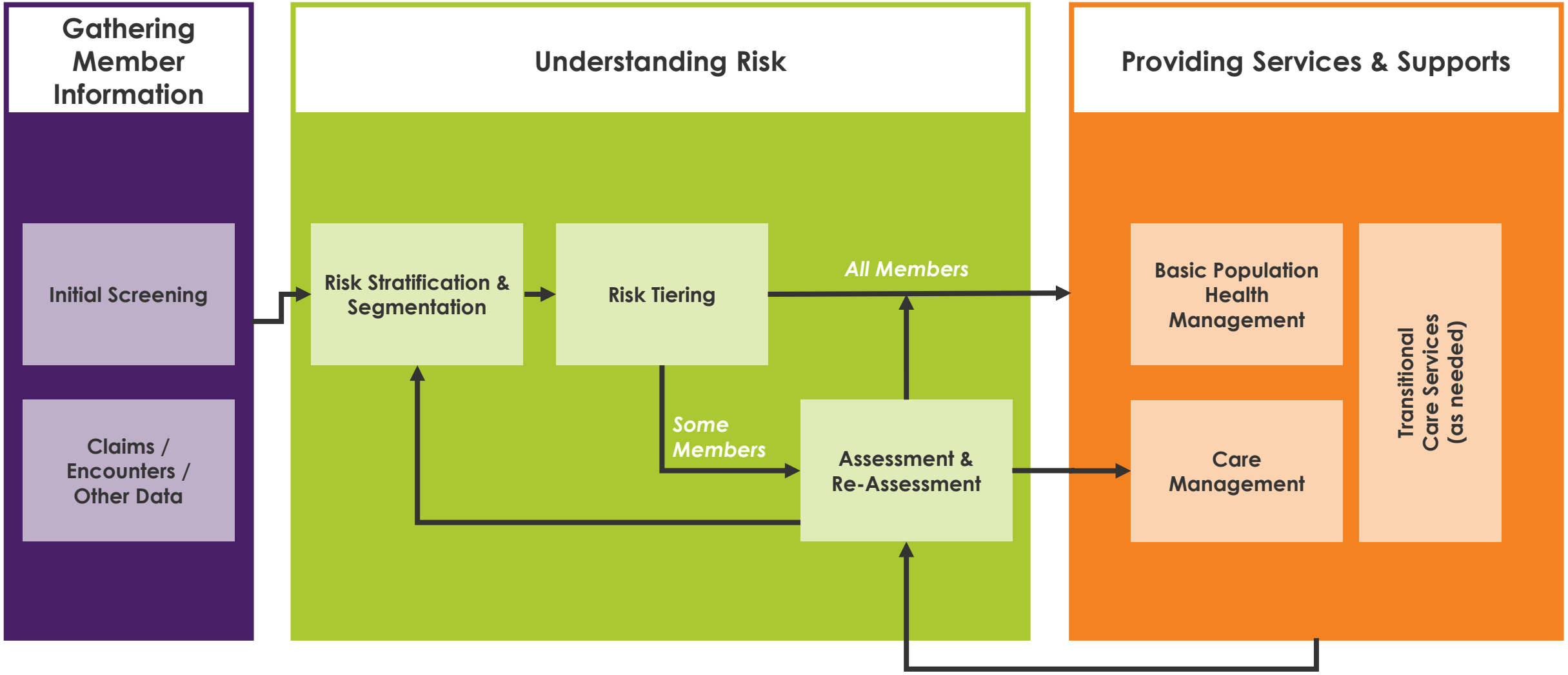
3

Provide timely services and supports

The next few slides cover the roles and responsibilities related to the 3 major components of the PHM Model:

1. Gathering Member Information
2. Understanding Risk
3. Providing Services and Supports

DHCS Model for Population Health Management



Model for Population Health Management: 4 block sample to help understand roles & responsibilities

Gathering Member Information

Plan Role
- Outreach for IHA/HIF
- HIE and data exchange
- Develop bidirectional data sharing

PPG Role
- Share data with IPA/ providers/Plan
- Support data infrastructure
- Screen patients/IHA
- Encourage Cozeva participation

Facility Role
- Share insights for the most common needs members have
- Help us inform our PNA
- Share discharge records timely

Community Role
- Share insights for most common needs from mbrs
- Street Med, CHW, ECM, CS provider assessment inputs
- Help us inform our PNA

Understanding Risk

Plan Role
- Share risk score/tier multidirectionally
- Identify the most current risk score/tier
- Share our risk algorithm

PPG/Provider Role
- Share risk score/tier bidirectionally
- Share your risk algorithm w/ Plan
- Prioritize activities based on risk

Facility Role
- Understand the risk score/tier
- Help inform the risk score/tier
- Prioritize activities based on risk

Community Role
- Understand/inform risk score/tier
- Share your risk algorithm w/ Plan
- Prioritize activities based on risk

Providing Services & Supports

Plan Role
- Connect members to services and supports
- Provider BPHM, CM, CCM, TCM
- Provide wellness, prevention, chronic disease mgmt

PPG/Provider Role
- Connect members to services & supports
- Share your PHM programs with Plan
- Timely office visits
- Provide evidence based care

Facility Role
- Connect members to services and supports
- Collaborate with CM for effective/ efficient discharge
- Schedule follow-up appt by discharge

Community Role
- Connect members to services and supports
- Promote local awareness and engagement
- Work with other organizations

IHA = Initial Health Appt
HIF = Health Information Form
IPA = Independent Physician Association
PPG = Participating Physician Group
PNA = Population Needs Assessment

BPHM = Basic Population Health Management
CM = Care Manager
CCM = Complex Care Management
TCM = Transitional Care Management

DHCS Model for Population Health Management

Gathering Member Information

Initial Screening

Claims / Encounters / Other Data

Plan Role	Provider Role

• Include **HIF** in all member welcome packages, website, and member portal
• Plan will complete 3 outreaches to all members to complete the **HIF** within 90 days of enrollment and **IHA** within 120 days of enrollment
• Directly follow up on positive screening results
• Incorporate **HIF** findings into risk stratification for PSS
• Incentivize completion of **IHA**
• Promote education and collateral on importance of **IHA**
	• Complete **IHA** within 120 days for all new members and periodically re-administered according to requirements in the PHM Policy Guide and MCP Contract requirements.
	• Share **IHA** findings with Plan using Cozeva or Provider Portal
	  • An IHA must be completed for all Members An IHA:
	  • Must be performed by a Provider within the primary care medical setting.
	  • Is not necessary if the Member's Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous 12 months.
	  • Must be provided in a way that is culturally and linguistically appropriate for the Member.
	  • Must be documented in the Member's medical record.
	• An IHA must include all of the following:
	  • History of Member's physical and mental health
	  • Identification of risks
	  • Assessment of need for preventive screens or services
	  • Health education
	  • The diagnosis and plan for treatment of any diseases
	• Encourage and support members to complete their **HIF** if seen w/in 90 days
	• Share **HIF** findings with Plan using Cozeva or Provider Portal
	• IHEBA/SHA is no longer required, however it's still a best practice to use this assessment to collect information on the member

• Capture all provider encounter and claims information to support risk assessment and stratification • Connect with HIEs, SHIEs and other exchanges to capture member data including housing status, ADT, etc. • Using the DHCS Population Health Service data and historical files	• Submit timely claim and encounter data that captures **IHA** completion • Submit **IHA** and HIF completion date through Cozeva • Leverage the DHCS Population Health Service once available.

DHCS Model for Population Health Management

Understanding Risk (Risk Stratification / Segmentation / Tiering (RSST) – Prior to PHM Service launch (process will change post-launch)

	Plan Role	Provider Role

Risk Stratification & Segmentation	• Plan must use the PHM Service or their own RSS approach and will include:
	  • Findings from the PNA
	  • Members' behavioral, developmental, physical, and oral health, Long- Term Services and Supports (LTSS) needs as well as health risks, rising-risks, and health-related social needs due to SDOH
	  • Risk stratify and/or segment all Members at least annually and during each of the following timeframes:
	  • Enrollment and annually
	  • Significant change in the health status or level of care
	  • Occurrence of events or new information that Contractor determines as potentially changing a Member's needs
		• Providers with internal algorithm can supplement their algorithm with Plan risk data

Risk Tiering	• Plan will assign members to risk tiers based on risk stratification & segmentation	• Providers with internal algorithm can supplement their algorithm with plan tier data for appropriate treatment and care.

DHCS Model for Population Health Management

Understanding Risk

Assessment & Re-Assessment

Assessment Focus Areas	Plan Role	Provider Role
Members who are/have: • SPD • Receiving: IHSS, Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) Services • LTSS needs • Entering ECM/CCM • Children with Special Health Care Needs (CSHCN • On oxygen • Residing in acute hospital • Hospitalized w/in 90 days or 3 + hospitalizations in last year • 3 + ER visits in last year w/ high utilization of services (e.g., multiple Rx for chronic diseases) • BEH dx or developmental disability and ≥ 1 chronic medical diagnoses or social need (eg homelessness) • ESRD, AIDS, or recent organ transplant • Cancer • Pregnant; • On antipsychotic medication • On 15 or more prescriptions in the past 90 days • Self-report of a deteriorating condition • Other conditions as determined by the Plan, based on local resources.	• Work with providers to conduct assessment and integrate it with CM processes • Assess high risk members: ▪ Upon enrollment ▪ Annually ▪ During significant change in health or level of care ▪ After receiving new information that changes the member's risk and need	• Provide all preventive screenings • Conduct an additional assessment of members in a way that: • Is culturally and linguistically appropriate • Builds trust with the member • Defines the nature of the risk factor or problem • Determine a member's overall needs and preferences, health goals, and priorities • Aid in the development of specific treatment recommendations to meet the member's needs and preferences.

DHCS Model for Population Health Management

Providing Services & Supports

Basic Population Health Management

Plan Role

- Plan is ultimately responsible for BPHM
- Ensure programs and services are made available to all members regardless of the member's risk tier, at the right time and in the right setting
- Ensure members have an ongoing source of primary care;
- Ensure members are engaged with their assigned PCPs
  - Make appointments
  - Transportation
  - Providing health education on importance of primary care
- Identify disengaged members by race and ethnicity
- Address different utilization patterns
- Prevent duplication of services
- Authorize timely specialty services
- Provide full suite of wellness, prevention, and chronic disease management programs

Provider Role

- Ensure members receive annual visits, screenings, immunizations, timely care, care gap resolution, treatment, referrals
- PCP to play a key role in the Care Coordination functions

DHCS Model for Population Health Management

Providing Services & Supports

Care Management

Plan Role

- Design/implement CM to help Members gain or regain optimum health or improved functional capability in the right setting
- Include comprehensive assessment of Member's condition
- Determine available benefits and resources
- Develop and implement of a CMP with performance goals, monitoring and follow- up
- Provide interventions to meet needs of high and medium-rising risk populations, including longer-term chronic care coordination and interventions for episodic, temporary needs
- Incorporate disease-specific management programs: Asthma, Diabetes, Cardiovascular Disease, and Depression at minimum
- Provide self-management support and health ed
- Connect to Community Supports when medically appropriate and cost effective
- Assign a CM for every member receiving CCM, have an opt out process
- CM will collaborate with members and their family/support, hospitals, EDs, LTSS, physicians, PCP, nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions.
- CM will ensure all TCM activities occur discharge risk assessment, discharge planning documentation, necessary post-discharge services

Provider Role

- Encourage high risk members to actively participate with care manager and management programs
- Collaborate with CM to facilitate safe and successful transitions
- Refer in to Plan programs as appropriate
- Share information on your program and enrollment criteria with the plan

DHCS Model for Population Health Management

Providing Services & Supports

Transitional Care Services (as needed)

Plan Role

- Support discharge planning and connect members to all needed services and supports
- After TCS is complete: assign CM/single point of contact for all high-risk members
  - Coordinate with the discharging facility to ensure:
    - Complete discharge risk assessment
    - Creation of discharge planning document and share with member, providers etc
    - Provision of post-discharge services such as referral to at-home services or medication reconciliation
    - Follow-ups are scheduled
- Timely PA
- Knowledge of when members are in A/D/T process
- Timely follow-up for ED visits for mental health issues or SUD
- Refer to Community Supports, coordinate with county social service agencies, waiver agencies for IHSS / other HCBS
- Evaluate for all care settings appropriate based on condition, needs, preferences, circumstances
- Ensure all transitional care services are complete (including having a single CM) for all high risk members by 1/1/23
- Ensure all transitional care services are complete for all members by 1/1/24
- Be fully implemented for all members by January 1, 2024 across all settings and delivery systems

Facility Role

Facility Role:

- Communicate with the member on admission
- Be involved with the patient early regarding discharge planning
- Receive notification of hospital discharge
- Complete the discharge summary at time of discharge
- Schedule follow-up appointments by discharge
- Ensure prescriptions are available at the patient's pharmacy
- Educate the patient about self-management.

PCP Role

- Contact the patient post-discharge
- Ensure follow-up appointments with the PCP,
- Coordinate care; perform medication reconciliation
- Repeat above until medically stable
- Create access for patients with new symptoms
- Tack readmission rates
- Track and review frequently admitted patients.
- Refer to industry standards:
  - https://pubmed.ncbi.nlm.nih.gov/23873732/