The NCQA Population Health Management Resource Guide

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NCQA
Measurement
We can’t improve what we don’t measure

Transparency
We show how we measure so measurement will be accepted

Accountability
Once we measure, we can expect and track progress
Our flagship product covers 70% of people in HMOs, PPOs.
Health plan accreditation is a performance-based accreditation that is divided into two main components:

1. **STRUCTURE & PROCESS**: This component is evaluated using the HEDIS Performance Measures (Clinical) and CAHPS 4.0H (Patient Experience).

   - **HEDIS Performance Measures (Clinical)**: 50% of the score
   - **CAHPS 4.0H (Patient Experience)**: 50% of the score

Together, these components contribute equally to the overall performance-based accreditation.
Improving Health Plan Accreditation

Drivers

Systems, not silos

Health Plans

Clinically Integrated Networks

Practices
PHM Category in Health Plan Accreditation

QUALITY MANAGEMENT AND IMPROVEMENT

POPULATION HEALTH MANAGEMENT

NETWORK MANAGEMENT

UTILIZATION MANAGEMENT

CREDENTIALING AND RECREDENTIALING

MEMBERS’ RIGHTS AND RESPONSIBILITIES

MEMBER CONNECTIONS

PHM 1: PHM Strategy

PHM 2: Population Identification

PHM 3: Delivery System Supports

PHM 4: Wellness and Prevention

PHM 5: Complex Case Management

PHM 6: PHM Impact

PHM 7: Delegation of PHM
Population Health Management is...
NCQA & Janssen Sponsorship

www.NCQA.org/PHMResourceGuide
Why a PHM Resource Guide?

Goal and Audience
www.NCQA.org/PHMResourceGuide

Educate health plans on PHM principles and provide examples of how PHM can be achieved in practice to inspire their own activities.
What’s in the PHM Resource Guide?

5 Components
- The PHM Strategy
- Stratification & Resources
- Targeted Interventions
- Delivery System Support
- Measurement

Commonly Asked Questions
Relevant NCQA Programs
In the Field Examples
If I’m applying for NCQA Health Plan Accreditation, do I need to follow everything in this Guide?

No- organizations undergoing Health Plan Accreditation are required to meet the requirements as described in Health Plan Accreditation ONLY. The Guide is a supplemental educational tool intending to support an organization’s implementation of population health management.
PHM 1: PHM Strategy

Element A: Strategy
Description

Element B: Informing Members
Keeping members healthy.
Managing members with emerging risk.
Patient safety or outcomes across settings.
Managing multiple chronic illnesses.
Component 1

Four areas of focus

Goals

Targeted Populations

Health plan activities

Direct member programs

PHM Strategy
### Component 1: PHM Strategy

<table>
<thead>
<tr>
<th>EXAMPLES</th>
<th>Goal: 70% of members 50 years of age and older receiving two doses of the shingles vaccine.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep members healthy</td>
<td>• Targeted population: Members 50 years of age and older without prior history of severe allergic reaction to the vaccine.</td>
</tr>
<tr>
<td></td>
<td>• Programs or services: In-office education on the benefits of shingles vaccination and on-site vaccination clinics targeting the appropriate members.</td>
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<tr>
<td>Manage members with emerging risks</td>
<td>Goal: 40% of members with diabetes and no cardiovascular disease receive statin medications during the measurement year.</td>
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<tr>
<td></td>
<td>• Targeted population: Members 40–75 years of age diagnosed with diabetes who do not have clinical atherosclerotic cardiovascular disease.</td>
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<td></td>
<td>• Programs or services: Clinician review of member’s prescribed medications, educate targeted members on statins.</td>
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<tr>
<td>Patient safety</td>
<td>Goal: Improve home safety modifications (reduce clutter, tape down loose rugs, install grab bars in the bathroom) for members receiving long-term services and supports (LTSS) during the measurement year.</td>
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<td></td>
<td>• Targeted population: Members receiving LTSS and living at home, and individual assessment revealed the need for home safety modifications.</td>
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<td></td>
<td>• Programs or services: Referral to community-based or external organization to arrange for home modifications.</td>
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<tr>
<td>Manage multiple chronic illnesses</td>
<td>Goal: Reduce emergency department (ED) visits related to chronic pulmonary obstructive disorder (COPD) in target population by 3% compared with baseline, during the measurement year.</td>
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<tr>
<td></td>
<td>• Targeted population: Members 65 and older with a diagnosis of COPD.</td>
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<td></td>
<td>• Programs or services: Complex case management and longitudinal access to primary care.</td>
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</tbody>
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PHM 2: Population Identification

Element A: Data Integration
Element B: Population Assessment
Element C: Activities and Resources
Element D: Segmentation
Component 2

Population Stratification and Resource Integration

- Data Integration
- Population Assessment
- Social Determinants of Health
- PHM Activities and Resources
- Risk Stratification
Component 2: Population Stratification and Resource Integration

<table>
<thead>
<tr>
<th>Data Integration</th>
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<tr>
<td>Medical and behavioral claims*</td>
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<tr>
<td>Laboratory data*</td>
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<tr>
<td>Electronic health records*</td>
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<tr>
<td>Clinical management programs, such as case management, wellness programs*</td>
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<tr>
<td>Member-supplied data</td>
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<tr>
<td>Pharmacy claims*</td>
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<tr>
<td>Health appraisals*</td>
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<tr>
<td>Advanced data sources such as health information exchanges, all-payer data warehouses*</td>
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<tr>
<td>Demographic or census data</td>
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<tr>
<td>Data supplied by providers or practitioners</td>
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</tbody>
</table>
Component 2: Population Stratification and Resource Integration

Models of Risk Stratification

There is more than one model of risk stratification. A plan’s choice of model is contingent upon its structure and goals, and on the characteristics of its population. A plan can also create its own risk stratification or segmentation model to suit its population. Examples of common models include:

- **Adjusted Clinical Groups.** Uses the presence/absence of specific diagnosis from inpatient/outpatient services to predict utilization of medical resources for a specified period, age and sex. Individuals are then classified into 1 of 93 discrete categories with similar expected utilization patterns.

- **Hierarchical Condition Categories.** Seventy condition categories from selected ICD codes; includes expected health expenditures.

- **Elder Risk Assessment.** Age, gender, marital status, number of hospital days over the previous two years and selected comorbidities are used to assign an index score to each member over 60 years.

- **Chronic Comorbidity Count.** Based on publicly available information from the Agency for Healthcare Research and Quality’s (AHRQ) Clinical Classification software, the total count of selected comorbid conditions spanning six categories.

- **Minnesota Tiering.** Members are grouped into one of five tiers based on the number of conditions across each condition group (e.g., Tier 1 = 1–3 condition groups, Tier 2 = 4–6 condition groups).

- **Charlson Comorbidity Measure.** Predicts the risk of 1-year mortality for members with a range of comorbid illnesses. Based on administrative data, it uses the presence/absence of 17 comorbidity definitions to assign members a score from 1–20, increasing in comorbid complexity.

- **Identification of Febrile, Neutropenic Children with Neoplastic Disease** (Lucas et al.). Predicts severe infections in pediatric cancer patients using chills, hypotension, and leukemia/lymphoma diagnosis as predictors.
Component 2: Population Stratification and Resource Integration

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are economic and social conditions—where people are born, live, learn, work, play, worship and age—that affect a wide range of health, functioning and quality-of-life outcomes and risks; for example:

- Safe housing.
- Local food markets.
- Socioeconomic conditions.
- Access to educational, economic, and job opportunities.
- Transportation options.
- Social support.
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community).

How can I find community organizations to integrate into my services?

Many community organizations that provide useful services to a member population work with other health plans, health systems and local governments. It can be beneficial to locate those community organizations that are being used by similar organizations to yourself and that provide services that meet the needs of your members.

The ACA requires participating health plan networks to include essential community providers (ECP). Local health departments are beginning to partner with health plans to provide services (e.g., for TB, sexually transmitted disease, family planning) to historically underserved areas and populations.²⁴

Collaboration with community health boards can also be beneficial in forging partnerships with community organizations and resources, and can help align efforts between health plan and community partners to achieve high-priority population health goals.²⁵
Component 2: Population Stratification and Resource Integration

In-The-Field Examples and Tools:

- Philips Wellcentive
- Health Leads
- ActiveHealth Management
- Kaiser Permanente
- Evolent Health
- BlueCare Tennessee
- UnitedHealthcare
In-the-Field Examples and Tools: Philips Wellcentive

Problem: In 2012, MGM Resorts launched its Direct Care Health Plan (DCHP) for employees in Las Vegas as an alternative to the traditional PPO and HMO offerings. An issue affecting their success in improving the quality and lowering the cost of their healthcare was that primary care providers used different non-interoperable EHR applications or had no EHR system at all.

Process: The Philips Wellcentive solution aggregated and integrated data from a variety of sources that included primary care, specialists, hospitals, labs and pharmacies to create a “mini-HIE” for the DCHP program.

With the integrated solution in place, primary care providers can:
- View a single, actionable patient record for each patient.
- Easily identify gaps in care and implement actions to address them.
- Identify patients who may not be taking prescribed medications.
- Enter data in the EHR, regardless of vendor, and automatically populate the registry.

Results:
- 79% of diabetic patients enrolled in DCHP received HbA1c screening, compared with 53% of patients enrolled in the PPO offering.
- 62% of eligible members enrolled in DCHP received colorectal cancer screening, compared with 30.7% of patients enrolled in the PPO offering.
- 76% of members say their primary care provider office wait time is less than 15 minutes.

* The results and claims were not independently verified. NCQA makes no representations or warranties, and has no liability to anyone who relies on the results and claims.
Targeted Interventions

PHM 4: Wellness and Prevention

PHM 5: Complex Case Management
Component 3

Targeted, Person-centered Interventions

- Complex case management
- Chronic condition management
- Long-term services and supports
- Wellness and prevention programs
- Behavioral health management
Component 3: Targeted, person-centered Interventions

NCQA Programs
The NCQA Wellness and Health Promotion Accreditation program is a comprehensive assessment of full-service wellness providers. It is intended to help employers "get their money’s worth" when selecting wellness providers, by identifying vendors most likely to deliver on the employer’s priorities, such as workforce health and reducing absenteeism.

NCQA Programs
Accreditation of Case Management for LTSS is designed to support organizations that coordinate LTSS, such as Area Agencies on Aging and centers for independent living.

LTSS Distinction for Health Plans is designed to support NCQA-Accredited health plans and MBHOs that coordinate LTSS.
Component 3: Targeted, person-centered Interventions

How does the health plan screen chronic conditions? Which conditions should be intervened upon?

Deciding how to screen for these conditions and which conditions should be intervened upon is dependent on the population targeted. It is very common that members will have comorbidities and risk factors associated with chronic conditions that could impact their health. To address this, your health plan can prioritize matching members to programs such as condition management based on the presence of a condition, while also considering the impact of these comorbidities and risk factors that could put the member at further risk of disease.

What makes a member complex?

Complex members typically have multiple chronic conditions, multiple medications or a severe, uncontrolled condition. From a utilization perspective, complex members are usually the top 1%-5% of resource utilizers.

What’s the difference between case management and complex case management?

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services that meet the comprehensive needs of the member. Complex case management is a subset of case management aimed at members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.
Component 3: Targeted, person-centered Interventions

In-The-Field Examples and Tools:

- Essentia Health
- University of Texas Medical Branch
- Cognizant
- Sharecare, Inc.
- Neighborhood Health Plan of Rhode Island
- Partners in Care Foundation
PHM 3: Delivery System Supports

Element A: Practitioner or Provider Support
Element B: Value-Based Payment Arrangements
Component 4

Delivery System Support and Alignment

- Value-based payment arrangements
- Patient-centered medical home transformation
- Shared-decision making aids
- Data sharing
Component 4: Delivery System Alignment and Support

Value-based Payment Arrangements

- Pay-for-performance
- Shared savings
- Shared risk
- Two-sided risk sharing
- Capitation/population-based payment
Component 4: Delivery System Alignment and Support

NCQA Programs

NCQA’s PCMH Recognition program evaluates practices using a PCMH model of care. The PCMH Recognition program incorporates other programs and distinctions that demonstrate quality in more specialized areas:

- The Oncology Medical Home program helps facilitate team-based care by recognizing oncologists who use a patient-centered model to improve collaboration and health care delivery for cancer patients.
- Distinctions in behavioral health integration, reporting of electronic quality measures and patient experience reporting.

Plans can also support PCMHs in their transformation through:

- Gap analysis for the practice.
- Onsite training or coaching.
- Care management support.
- Educational support and learning collaboratives.
- Technical assistance.
- Financial incentives and support.

Providing these supports can facilitate building the foundation necessary to sustain practice transformation to the PCMH model of care and help practices meet quality improvement metrics foundational to PHM goals.⁶⁰
Component 4: Delivery System Alignment and Support

In-The-Field Examples and Tools:

- Washington State Health Care Authority
- Baylor Scott and White Quality Alliance
Element A: Measuring Effectiveness

Element B: Improvement and Action
Component 5

- Clinical Measures
- Cost/Utilization Measures
- Member Experience of Care Measures
- Tools to Set and Evaluate the Impact of the PHM Strategy

Measurement
Component 5: Measurement

Clinical Measures

Clinical measures focus on activities, events, occurrences or outcomes related to provision of clinical services; for example:

- **Outcome measures.** Incidence or prevalence rate for desirable or undesirable health status outcomes (i.e., members with controlled hypertension).
- **Process measures.** Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (i.e., immunization rates).

Examples of clinical HEDIS measures:

- **Persistence of Beta-Blocker Treatment After a Heart Attack.** The percentage of members 18 years of age and older during the measurement year who had a diagnosis of AMI and were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year, and received persistent beta-blocker treatment for six months after discharge.
- **Medication Management for People With Asthma.** The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.
Wellness and Prevention

**Chlamydia Screening in Women**, a measure in the HEDIS measure set, assesses the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Sexual activity is identified through pharmacy data (prescriptions for contraceptives) and claims/encounter data (denoting a service such as a pregnancy test or prenatal services).

Chronic Conditions Management

**Comprehensive Diabetes Care**, in the HEDIS measure set, assesses the percentage of members 18–75 years of age with diabetes (types 1 and 2) who had each of the following:

- HbA1c testing.
- HbA1c control (<8.0%).
- Eye (retinal) exam.
- Blood pressure control.

- HbA1c poor control (>9%).
- HbA1c control (<7.0%) for a selected population.
- Medical attention for nephropathy.

**Pharmacotherapy Management of COPD Exacerbation**, in the HEDIS measure set, assesses the percentage of COPD exacerbations for members 40 and older who had an acute inpatient discharge or ED visit in the measurement year and were dispensed appropriate medications (systemic corticosteroid within 14 days of the event and a bronchodilator within 30 days of the event).
In conclusion: Resource Guide

- Aligns with Health Plan Accreditation Standards
- Frequently Asked Questions
- NCQA Programs
- Relevant Measures
- In-The-Field Examples and Tools
NCQA & Population Health Management

**HPA 2018 PHM Standards**
Category of standards in Health Plan Accreditation 2018
July 2018

**PHM Prevalidation**
For health IT vendors performing discrete PHM functions
December 2018

**PHP Accreditation**
For population health organizations
December 2018
Questions