Managing a Population – The Primary Care Perspective

Introduction: What you will Find in This Module

Population management is an approach to planning the health care needs of all your patients by shifting the focus from individual patient visits to the entire population. Population management tasks vary depending on the type of practice; primary care includes ensuring each patient has an assigned physician or care team (empanelment), identifying patients that need extra help (risk stratification) and planning their care (care planning), ensuring that no patient "falls through the cracks" (care management), and using data to guide improvement. The TCPI Change Package includes change concepts that address each of these areas. Each can be considered and implemented independently, but it is their combined impact that results in a system of population management.

This module provides guidance on how to apply these change concepts to population management in a primary care setting. Each section begins with a link (or links) to relevant sections of the TCPI Change Package where you will find related resources.

Empanelment

1.3.1 Assign to panels: Use a data-driven approach to assign patients to panels and confirm panel assignments with both providers and patients

The first step is to define the population that you manage. Is it everyone treated in the past twelve months? In the past two years? Looking back two years is a common convention, but the definition of your population needs to make sense for your practice. For example, if your practice is in a resort area, it may not make sense to assume responsibility for the many visitors that may be one-time patients. At the same time, a managed care organization may have assigned patients to your practice that you have not yet seen; you should still include them. Once you choose the best definition of your practice's population, then you can assign each patient to a specific provide, known as empanelment. Empanelment is the first step in building a relationship between a patient and his/her provider and associated care team. For advice on approaches to empaneling patients, see page 13 of the Safety Net Medical Home Foundation's *Empanelment* toolkit. You will also find tips on empanelment on the AHRQ *Facilitating Panel Management* site.

Empaneling each patient to an individual provider means that the provider and his/her team assume responsibility for a specific group of patients served by the practice. Once patients are assigned to panels, the practice can begin the work of ensuring patients are seen by their assigned provider or team whenever possible and manage the needs this population.

Note: if you are a solo practitioner, you do not need to empanel your patients. All patients seen by the practice are assigned to you!

Risk Stratification and Care Planning

1.3.3 Stratify risk: Stratify the population based on risk and complexity and provide care appropriate to risk level
1.6.2 Plan care: Plan care according to the evidence base and related patient needs and preferences, including social determinants of health

To implement population management, your practice will need a method to differentiate patients requiring specific types and intensity of care. This means having a consistent approach to routinely assess the needs of each patient and a plan of care for each patient that supports those needs. This is known as risk stratification and usually involves the use of a standard tool. Payers use sophisticated tools based on large data sets, but simpler options that practices can use are also available. Widely used examples include the PRAPARE or BOOST 8P Screening Tool.

You may choose to systematically assess all patients, or you may also decide to begin on a smaller scale by identifying patients with a single risk factor, such as high A1c or frequent ED visits. For each risk level, the practice should have basic elements of a plan that can guide the care for the various patient groups and address the unique needs of each group. In some cases, practices may identify patients as needing preventive care only. For others, their chronic condition may warrant regular assessment and follow up. For still others, a higher level of ongoing intervention in the form of care management may be needed. The plan should draw upon the evidence base where appropriate.

Identify and Decrease Care Gaps

1.3.5 Identify care gaps: Use population data or registries to identify and act on gaps in care for prevention or defined diagnoses
1.6.4 Decrease care gaps: Use point of care reminders and population/ panel reports to decrease care gaps

Providing optimal care for an entire population by identifying and eliminating care gaps is the aim of population management. It is a structured approach to ensure the people served by your practice receive the evidence-based care you want them to have. Using data for different groups of patients defined by condition or other characteristics, along with care plans the practice developed for each group, provides a data-driven framework for reviewing and adapting the plan of care to meet individual patient needs.

For example, you might choose to focus on patients with diabetes. By running a report from your EHR, you could segment patients into three groups: those with an A1c less than 7.0, between 7.0 and 9.0, and over 9.0. Patients with good A1c control can be followed every six months for their diabetes and age-appropriate health maintenance needs. Patients in the middle group are typically seen every three months or so and may need a little more support. Approaches such as self-management goal setting, health coaching and group visits are often

successful in helping patients improve their diabetes control. Those with diabetes in poor control need an even higher level of intervention. Team members often access patients who struggle for additional complicating factors such as social determinants of health, an uncontrolled behavioral health disorder, or other barriers. For those patients who are willing to make changes, support such as diabetes educators, partnerships with community agencies, and a dedicated care manager can make a difference. As patients' control of diabetes improves, the risk level improves, and the resources needed taper. In this way, resources are consistently matched to the level of support needed for each segment.

Implementing this approach will ensure that patients receive optimal care and will demonstrate to payers that the practice delivers high-value, evidenced-based, efficient services. For more information on implementing care plans, see the Safety Net Medical Home Initiative's *Evidence Based Care* toolkit.

Next Steps in Population Management

Once you empanel your patients and begin population management, you may want to consider strengthening the practice's relationships with other care providers that patients depend on. This network of providers, including primary care providers, specialists, social service agencies, and others make up "the medical neighborhood." By building relationships with other providers, you will find opportunities to offer more complete and efficient care to your patients. You may want to further review the Change Package at the links below for more information:

- **1.5.2 Establish medical neighborhood roles: Establish clear expectations among primary care team, specialists and others in the medical neighborhood about the role each will play in a patient's care and the information that each will share**
- **1.5.3 Coordinate care: Provide effective care coordination across the medical neighborhood**