Population Health Learning Activity: Population Health Management Review			
Relevant PCMH Concepts	**Patient-Centered Access and Continuity (AC)** The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.	**Care Management and Support (CM)** The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.	**Knowing and Managing Your Patients (KM)** The practice captures and analyzes information about the patients and community it serves, and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
Relevant PCMH Competencies & Criteria	<u>Competency A: Patient Access to the Practice</u> The practice enhances patient access by providing appointments and clinical advice based on patients' needs. ○ *AC09*: Uses information about the population served by the practice to assess equity of access that considers health disparities.	<u>Competency A: Identifying Care Managed Patients</u> The practice systematically identifies patients who may benefit from care management ○ *CM01 (Core)*: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): ▪ Behavioral health conditions ▪ High cost/high utilization ▪ Poorly controlled or complex conditions ▪ Social determinants of health	<u>Competency C: Addressing Patient Needs</u> The practice proactively addresses the care needs of the patient population to ensure needs are met. ○ *KM12 (Core)*: Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories): ▪ Preventive care services ▪ Immunizations ▪ Chronic or acute care services ▪ Patients not recently seen by the practice.

Relevant PCMH Competencies & Criteria		▪ Referrals by outside organizations, practice staff,patient/family/caregiver. ○ *CM02 (Core)*: Monitors the percentage of the total patient population identified through its process and criteria. ○ *CM03*: Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.	
Learning Objectives (with relevant IPEC Core Competencies)	○ Express one's knowledge and opinions to team members involved in patient care and population health improvement with confidence, clarity, and respect, working to ensure common understanding of information, treatment, care decisions, and population health programs and policies (CC3). ○ Engage diverse professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and healthcare needs of patients and populations (RR3). ○ Use process improvement to increase effectiveness of interprofessional teamwork and team-based services, programs, and policies (TT9). ○ Place interests of patients and populations at center of interprofessional health care deliver and population health programs and policies, with the goal of promoting health and health equity across the lifespan (VE1).		
IP Student Learning Activity	An IP student team assesses the current strategies used by the practice to systematically identify and manage the health of its patient population, including those used to address the criteria noted above. The team: ○ Identifies areas of effectiveness and potential gaps (incorporating data from the ***Population Health Profile Learning Activity*** if available); ○ Determines if current practice adequately identifies and addresses the population's needs, as evidenced by achieving or exceeding practice-specific goals and/or other accepted benchmarks; ○ Conducts a literature review to identify evidence-based strategies and/or best practice for (complex) patient identification, risk stratification, outreach and/or intervention specific to the population's identified health or healthcare need(s); ○ Identifies strategies to improve patient care.		
IP Student Learning Assessment	The student team will compile the above information into a report that includes the findings of their review and recommendations for improvement. The report will be presented to appropriate members of the practice team who will comment on the students' work and determine appropriate improvement action.		

	Following this presentation, the student team and facilitator will debrief the experience of working together as a team on this Learning Activity.
Resources	○ Population health management is "a set of interventions designed to maintain and improve a patient's health across the full continuum of care – from low-risk, healthy individuals to high-risk individuals with one or more chronic condition(s)" (Felt-Lisk & Higgins, 2011) ○ Bright Futures Recommendations for Preventive Pediatric Health Care (AAP) ○ Children's Health Care Quality Measures (CMS) ○ Electronic Preventive Services Selector (EPSS) (AHRQ) ○ Immunization Schedules (CDC) ○ Population Health Management and Risk Stratification: The First Steps Toward Value-Based Payments (Care Transitions Network, n.d.) ○ Population Health Management: Risk Stratification (NACHC, 2017) ○ Predict, Prioritize, Prevent (Colorado Beacon Consortium, 2013) ○ TeamSTEPPS Debrief Checklist ○ The Community Guide: The Guide to Community Preventive Services (DHHS – Community Preventive Services Taskforce) ○ The Playbook. Developed by the Institute for Healthcare Improvement, it provides users with the best available knowledge about promising approaches to improve care for people with complex needs. ○ Tools for Primary Care Providers (USPSTF) ○ Women's Preventive Services Guidelines (HRSA, 2016) ○ IPEC Core Competencies (2016) ○ NCQA PCMH Standards and Guidelines (2017)