Population Health Management & Long-term Services and Supports

August 9, 2022

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Before We Get Started

Message Lisa Silverman for any ***tech issues***

Use the chat box for ***questions*** and to ***introduce yourself***

Explore ***resources*** we'll share in the chat box

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OPENING POLL

What URAC accreditation is your company accredited under or applying for?

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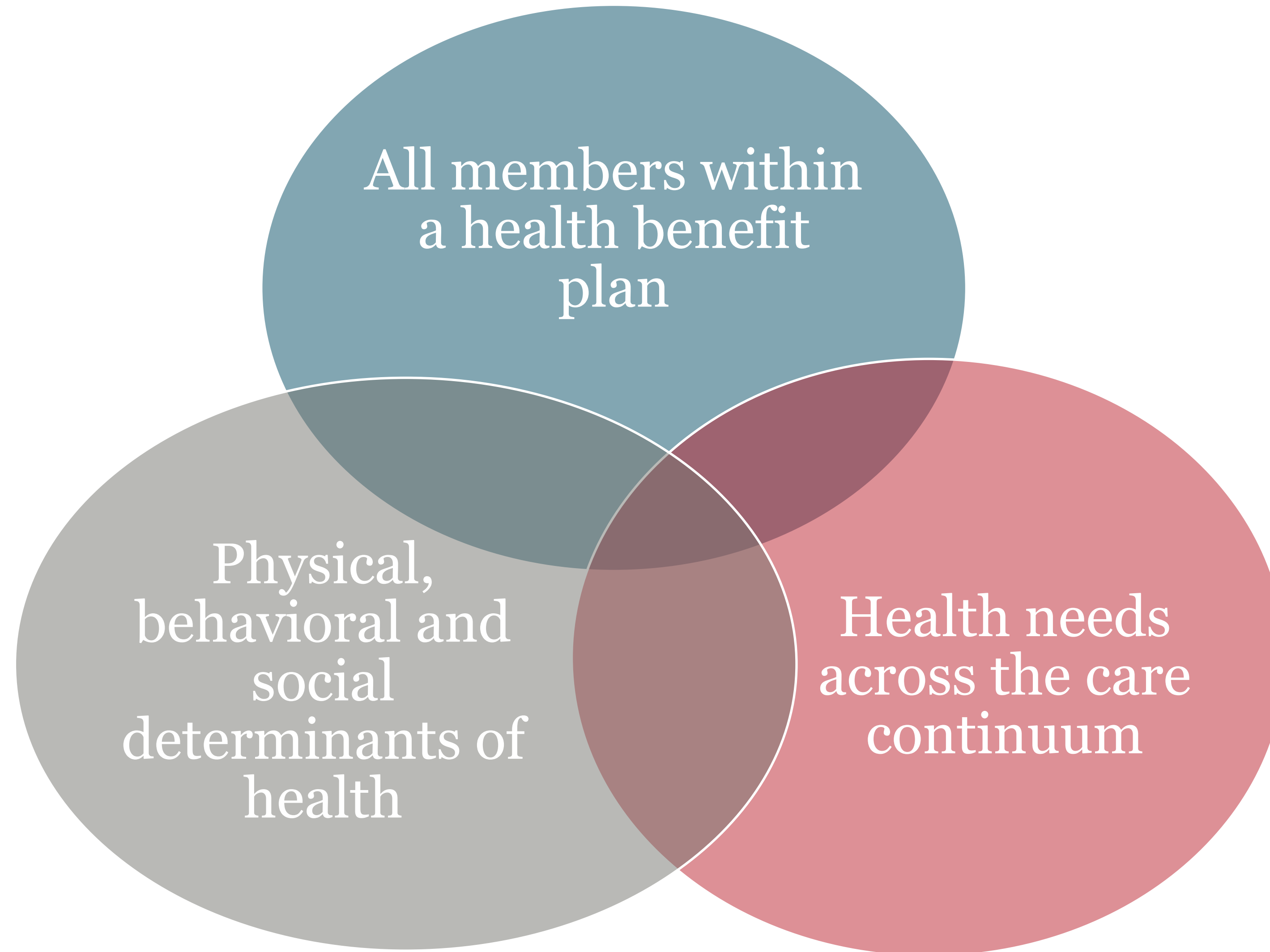
PHM 1-1: Scope of Population Health Management



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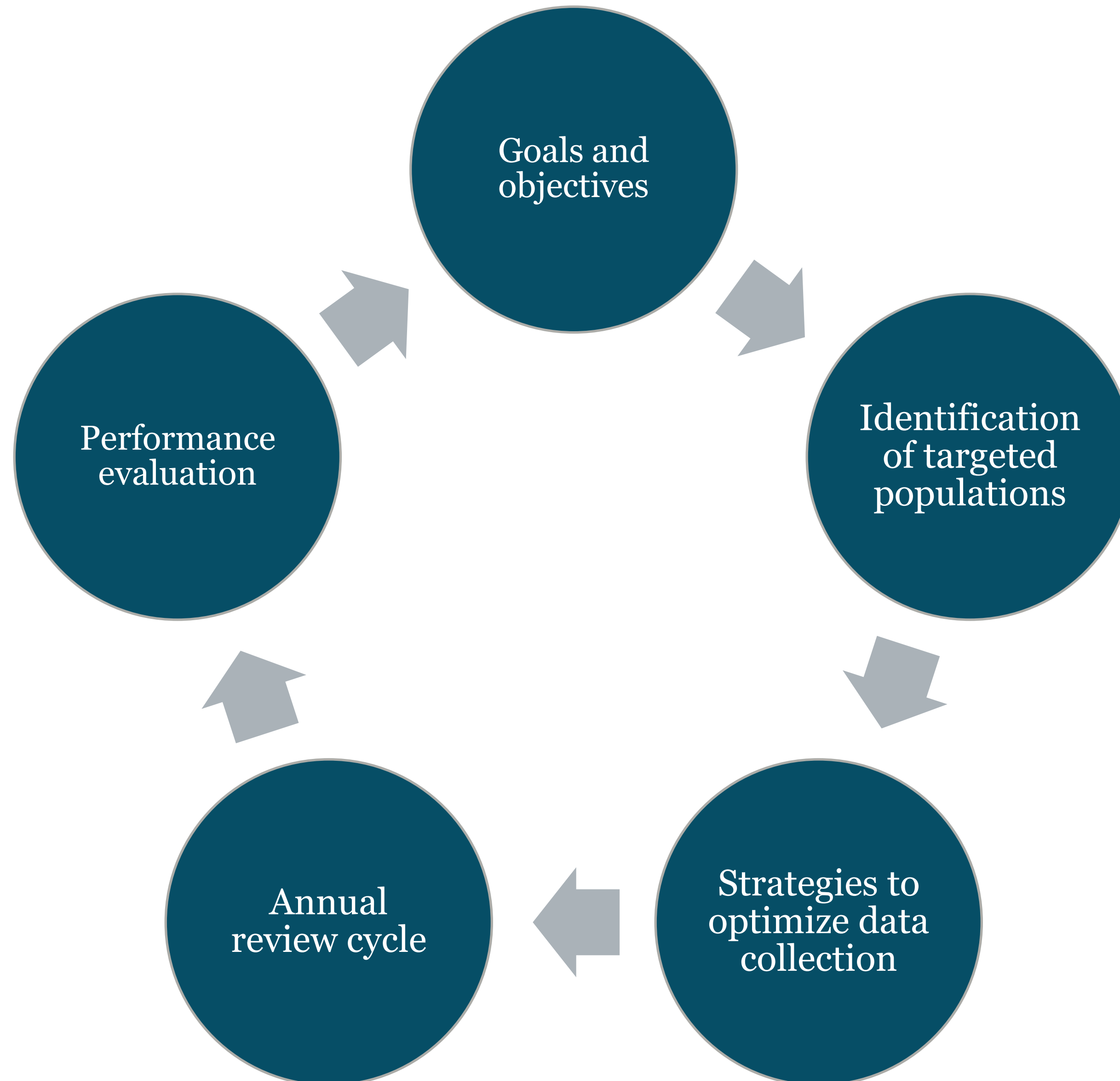
PHM 2-1: Approach to Population Health Management



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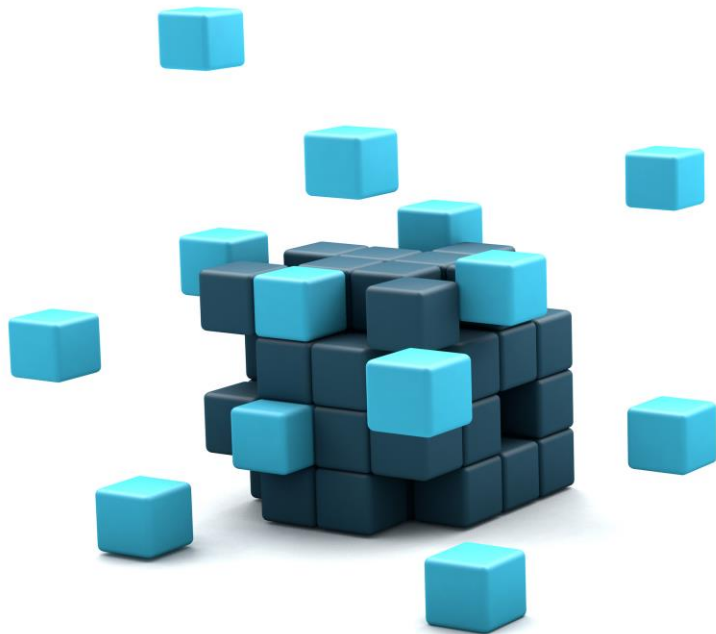

What is your organization's strategy?

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PHM 2-1: Approach to Population Health Management

Types of interventions and incentives to improve health outcomes?	Goal/objective: What is the success rate of interventions? PHM 3-3.a.i
Services offered and the entities providing them?	Goal/objective: Trends in member experience of care and services PHM 3-3.a.iii
Implement and monitor population health initiatives?	Goal/objective: Member participation rates PHM 2-2.a.iii Member access to prescribed therapies PHM 4-1.a.iii

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PHM 2-2: Member Communications and Participation

Strategies for member engagement

Communication of available member services and resources

Member rights to opt-in or opt-out of participating

The need for member consent for services

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PHM 3-1: Baseline Health Status and Needs

Given the available data, establish:

Need for preventive services

Prevalence of at-risk, chronically ill and poly-morbid conditions

Impact of known SDOH

Barriers to data collection

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PHM 3-2: Ongoing Population Health Monitoring

Monitor the health needs and characteristics of its populations

Determine areas for interventions for identified sub-populations

Establish the metrics against which interventions will be measured

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PHM 3-3: Annual Population Health Management Evaluation

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PHM 4-1: Participating Provider Support

Incentives that align with value-based reimbursement

Evidence-based clinical decision support tools/ decision aids

Maximize member access to therapies

Facilitation of provider-member communication

Care coordination and case management

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PHM 4-2: Strategic Partnerships

- Partners from health care delivery system and/or community at large

- Goal is to secure the resources and services to achieve population health goals

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PHM 5-1: Structured Case Management Services

Desktop Review: Policies and processes on structured case management services address:

- Standardized processes are used for assessment, care planning, implementation, coordination, monitoring and evaluation
- The program is consistent with evidence-based clinical guidelines

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PHM 5-2: Members Identified for Case Management

- Physical, behavioral, cognitive and/or psycho-social screening tools
- Mining of data sources
- Health care practitioner referrals
- Facility and outpatient services referrals
- Member, family or caregiver referrals

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Standard PHM 6: Comprehensive Assessment

PHM 6-1: Assessment Categories

PHM 6-2: Medication Review, Assessment and Interventions

PHM 6-3: Member Input Into Assessment

PHM 6-4: Assessing Available Resources

PHM6-5: Assessing Coordination Needs

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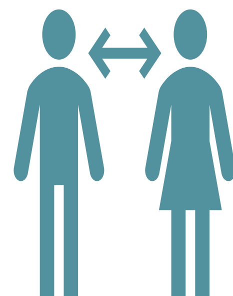
PHM 7-1: Person-Centered Care Plan Features

Member input is used to establish goals and timelines



Family, caregivers and health care providers contribute to the care plan

Interventions correlate with goals/outcomes with input and agreement from member

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PHM 7-2: Additional Care Plan Features

- Evaluate response interventions and any barriers to goals
- Address emergencies
- Document care plan re-evaluation time frame

PHM 7-3: Ongoing Care Plan Management

Care plan documentation reflects ongoing care plan management.

Care plan assessment and goal achievement occurs at least annually.

Did the member follow up with referrals?

Is the care plan still appropriate and accepted?

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PHM 7-4: Closure of Case Management Services

- Achievement of targeted outcomes and goals
- Maximum benefit to the member is reached
- Barriers or concerns related to the closure of case management services
- Rationale for closure based on objective data and circumstances
- Communication with the member, family, caregivers and collaborative team members

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Long-term Services and Supports

LTSS is an optional module for Health Plan and Medicaid Health Plan

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POLL QUESTION

Is your organization providing or planning to provide long-term services and supports?

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LTSS 1-1: Program Structure

Theme repeated in several URAC accreditations:

- Goals and objectives are evaluated
- Annual program review
- Program is updated as needed

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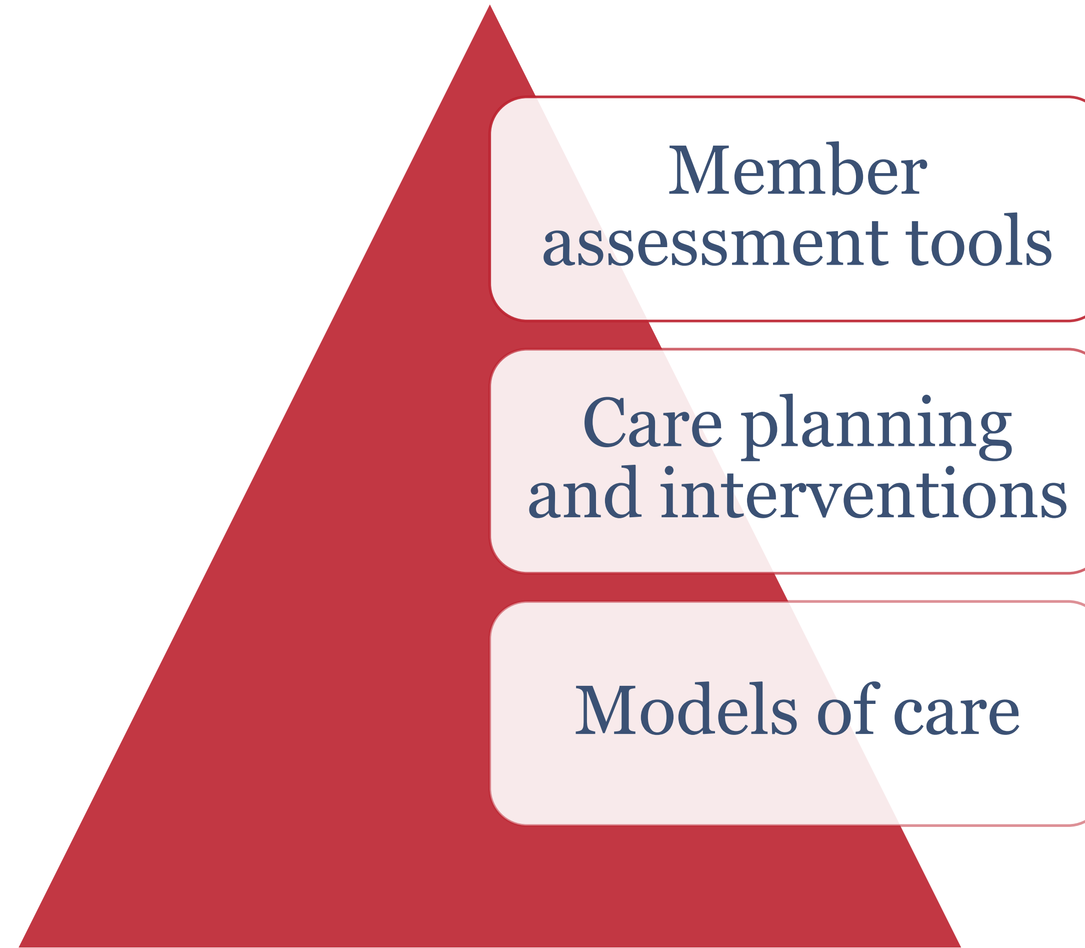
LTSS 2-1: Evidence-Based Program Components



LTSS 2-2: Person-Centered Assessment and Care Planning

Input, as well as family and caregiver input as appropriate

Values, preferences and priorities

Informal (i.e., unpaid) caregiver needs as applicable

Ability, as well as choice, to self-direct care and engage in self-care

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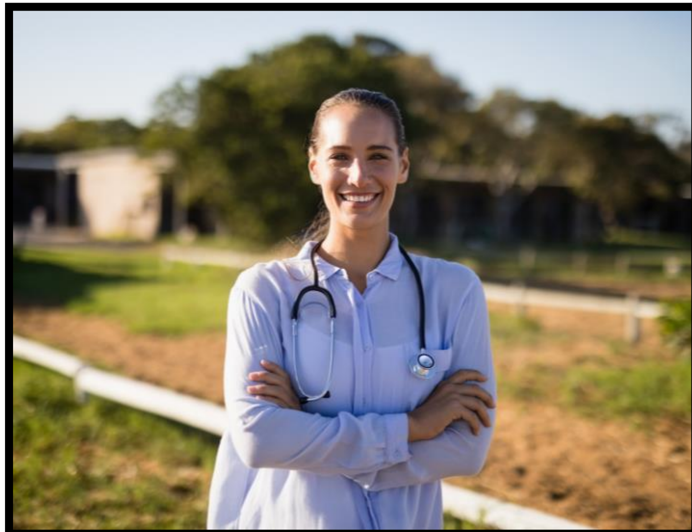
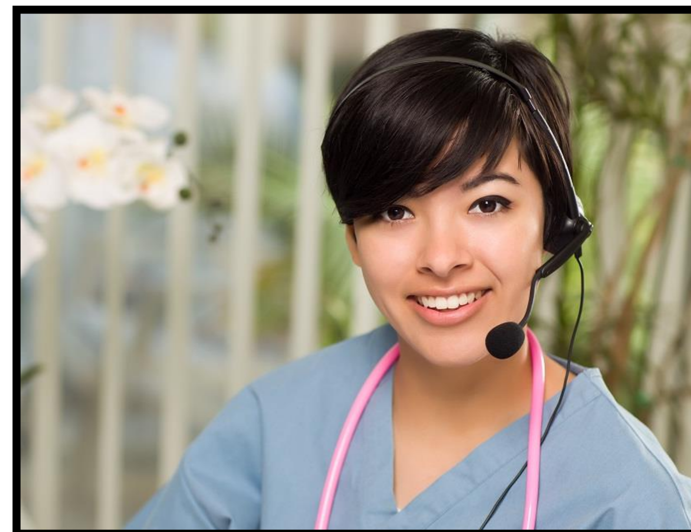
LTSS 3-1: LTSS Program Resources

Field case management

Dedicated contact center personnel with direct access to LTSS case managers





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LTSS 3-2: Coordination and Alignment of Community-based Resources

- Community-based organizations are integral to providing long-term services and supports to members and achieving care plan goals
- Criteria for making a referral may be mutually established by the parties involved

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Case Management Standards for LTSS

REQUIRED FOCUS AREA:

Population Health Management

- PHM 6: Comprehensive Assessment
- PHM 7: Person-Centered Care Plan

OPTIONAL MODULE:

Long-Term Services and Supports

- LTSS 4: Comprehensive Assessment
- LTSS 5: Person-Centered Care Plan

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Case Management Standards for LTSS

REQUIRED FOCUS AREA:

Population Health Management

- Health Plan
- Medicaid Health Plan
- Marketplace Health Plan

OPTIONAL MODULE:

Long-Term Services and Supports

- Health Plan with LTSS
- Medicaid Health Plan with LTSS

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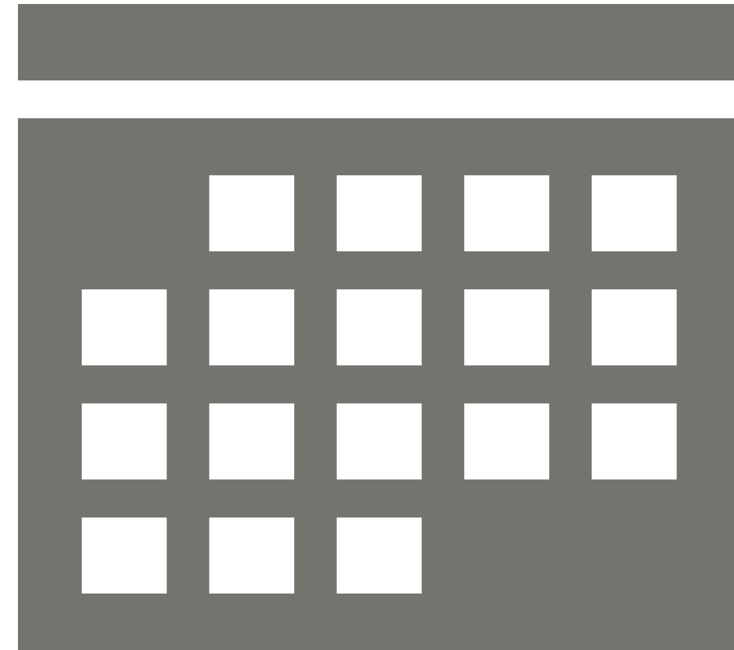
LTSS 6-1: Measuring & Improving the Member Experience

Performance goals are set by the organization



Measurement is at least annually

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LTSS 6-2: Measuring and Improving LTSS Program Effectiveness

Annual reporting on process or outcome metrics related to:

- Member assessment
- Member care plan
- Program management of incidents that impact care plan outcomes

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Upcoming Events

Webinars

- Monthly AccreditNet Training
  - Wednesday, August 10, 2pm Eastern
- Expert Perspectives: Digital Health and Quality Care
  - Wednesday, August 24, 1pm Eastern
- Medicaid Module
  - Friday, September 9, 2pm Eastern

Find more information at clients.urac.org

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