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Population Health Management Assessment Tool (PhmCAT) Office Hours

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Agenda

1. Welcome
2. Review of the Population Health Management Capabilities Assessment Tool (PhmCAT)
3. Next Steps

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Welcome

Please:

Rename yourself

1

Click the Participants icon

2

Hover over your name & click Rename

3

Add your name, pronouns and organization

4

Click OK

If you connected to the audio using your phone

- Find your participant ID; it should be in the top left of your Zoom window
- Once you find your participant ID, press: #number# (e.g., #24321#) to connect your audio and video
- The following message should briefly appear: “You are now using your audio for your meeting”

May 2025 Deliverables

Templates are available for download on the Milestones page.

Category	Milestone	Deliverable
PhmCAT	**Complete year 2 PhmCAT**	Assessment
Data to Enable Population Health Management	**Data implementation plan:** Develop implementation plan for addressing data and technology gaps and transforming practice operations to support development of KPIs. Plan must include steps for implementing these three strategies: 1. Identifying and outreaching to the assigned but unseen population 2. Using gaps in care reports that include practice and MCP data 3. Data exchange with 2 external partners, at least 1 of which is a Qualified Health Information Organization (QHIO) Note: Before completing this Milestone, the team needs to have submitted Milestone 4: Data governance and HEDIS reporting assessment	Implementat-ion Plan
Stratified HEDIS®-like measures	**Stratify HEDIS®-like measures:** Submit report that includes HEDIS®-like measures applicable to selected population of focus stratified by race and ethnicity and at least one additional characteristic: primary spoken language, sexual orientation, gender identity, housing status, or disability status.	Stratified HEDIS-like measures
Key Performance Indicators (KPIs)	**Submit KPI Updates:** Empanelment, Continuity, and Third Next Available Appointment Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission. **Report on HEDIS-like Population of Focus Measures:** Reporting for QI purposes (not for payment)	KPI Report
Nov 2024 Deliverables	If needed, EPT practices may also submit the **Empanelment Assessment, Empanelment Policy and Procedure, Data Governance Assessment, and Data Governance Policy and Procedure**.	See details per deliverables

PhmCAT Overview

The PhmCAT provides an overview of your practice's baseline across key PHM domains, including to identify strengths and areas of opportunity.

This is the second annual PhmCAT submission. EPT practices will also complete the PhmCAT in 2026.

Practices and the Learning Center will use results to understand practice PHM capabilities, look at change in capabilities from 2024 - 2025, and inform EPT TA opportunities.

PhmCAT Survey Reminders

PhmCAT is due **May 1st**

Who should complete the PhmCAT?

- All practices must at least **3 roles** represented and ***completed individually in the EPT Deliverable Portal.*** The Learning Center highly recommends that the staff who completed the PhmCAT in 2024 complete it in 2025.
  - 1 Provider
  - 1 Clinic front-line (MA or Nurse)
  - 1 administrative/office manager
- Note – Small practices (3 FTEs or less) may have fewer respondents

Additional respondents can be helpful

- Practices that have the following roles should obtain PhmCAT responses from them:
  - Executive Sponsor (e.g., CEO, COO)
  - Clinical Lead (e.g., CMO, CNO, medical director)
  - Finance Lead (e.g., CFO, accounting manager)
  - Data and technology lead (e.g., CIO, IT director, etc.)
  - Quality Lead (e.g., quality manager/director)

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Keep in Mind

- Intent of the PhmCat
  - Obtain a snapshot: Where is your organization now?
  - The PhmCat is based on “best practices” and “high performers” and helps identify areas for future work.

- There is NO CUM LAUDE Score for the PhmCAT!
  - Be thoughtful and reflective
  - Give credit where credit is due
  - **“I DON’T KNOW”** is a valid answer
  - If your TEAM completes the PhmCat, funding will be received; your scores do not impact payment.

- 2024 practice-level PhmCAT responses will be available in the Deliverables Portal.

How does this compare to the 2024 submission?

What is the same?

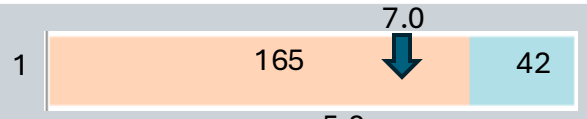
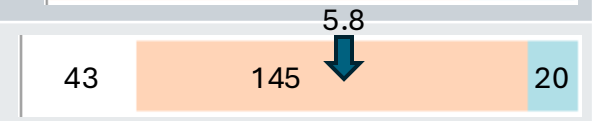
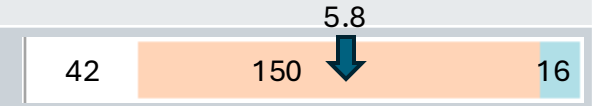
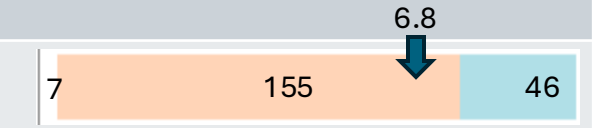
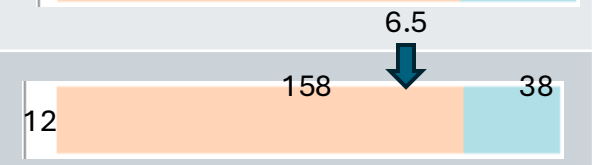
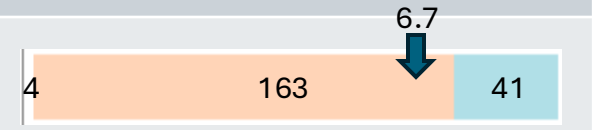
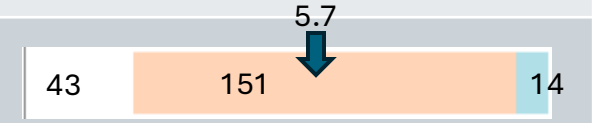
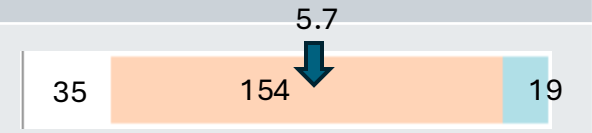
- The PhmCAT survey tool.
- Guidance regarding the role and number of respondents from each EPT practice.
- Responses will be used to gain insight into practice strengths and areas of opportunity.
- Payment will be achieved if the practice completes the PhmCAT.
  - Your scores are not tied to payment.
- PHLC will provide a practice-level report back to each EPT practice.

What is new?

- EPT practices will complete the PhmCAT and can view practice-level results through the EPT Deliverables Portal.
- Each person completing the PhmCAT will need their own EPT Deliverables Portal log-on.

2024 Baseline PhmCAT Results
Room For Improvement Across All Domains

Legend:
- # of Practices with Limited Capabilities
- # of Practices with Some Capabilities
- # of Practices with Strong Capabilities
- Domain average

Domain	Capability Optimized	Practice-Level Results
Leadership & Culture	Quality work is everyone's responsibility and leaders systematically use data to drive clinical and business decisions.	
Business Case for Pop Health Management	Solid understanding of financial performance, capacity to manage performance-based and VBP contracts.	
Technology & Data Infrastructure	Multiple data sources integrated into EMR to address disparities and close care gaps both with engaged and unengaged patients.	
Empanelment & Access	Provider continuity with assigned PCPs; timely care accessed in person, through telehealth and patient portals.	
Care Team & Workforce	Multidisciplinary team performing at top of their license with documented workflows, standing orders, and self-management support.	
Patient-centered population-based care	Registry data used for pre-visit planning and to proactively outreach to patients on overdue care or in need of referrals.	
Behavioral Health	BH services readily available through onsite staff or agreement with outside organization that includes routine screening and referrals.	
Social Health	Universal screening identifies patients' high impact social needs and referrals to community-based services are tracked and followed up on.	

8 PhmCAT Domains – 50 Questions

- Leadership & Culture (q. 1-7)
- Business Case for PHM (q. 8-12)
- Technology and Data infrastructure (q. 13-19)
- Empanelment & Access (q. 20-24)
- Care Teams (q. 25-30)
- Patient-Centered, Population-Based Care (q. 31-40)
- Behavioral Health (q. 41-45)
- Social Health (q. 46-50)

Leadership & Culture

- This section measures the organization's leadership and culture across a continuum for executive and clinical leaders.
- Does your organization…
  - Support continuous learning
  - Embed quality improvement activities and resource those activities
  - Have a culture that priorities equity including in staffing and strategic initiatives
  - Advance equity goals as part of the organization mission to meet the needs of the communities they serve
  - Have environment that promotes team culture, supports problem solving with full support from leadership.

Sample Leadership & Culture Questions

Leadership & Culture

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

1. Executive leaders[1]	…are focused on short-term business priorities.		…visibly support and create an infrastructure for quality improvement, but do not commit resources.		…allocate resources and actively reward quality improvement initiatives.			…strongly support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

2. Clinical leaders[1]	…intermittently focus on improving quality.		…have developed a vision for quality improvement, but no consistent process for getting there.		…are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.			… consistently champion and engage care teams in improving patient experience of care and clinical outcomes and provide time, training, and resources to accomplish the work.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

3. The responsibility for conducting quality improvement activities[1]	…is not assigned by leadership to any specific group.		…is assigned to a group without committed resources.		…is assigned to an organized quality improvement group who receive dedicated resources.			…is shared by all staff, from leadership to team members, and is made explicit through protected time to meet, and with specific resources to engage in quality improvement.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

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Business Case for PHM

- The purpose of this domain is to determine where the organization is with planning a sustainable business model that includes investing in **population health, quality, equity**, and aligns with new payment models that advance these priorities.

- Business case for pop health management considers…
  - Quality results are used to identify opportunities for improvement
  - Experience in value based payment
  - How your organizational equity goals are reflected in operations
  - Aligning budget and operational decisions with equity priorities

Sample Business Case Questions

8. The organization has a solid understanding of its current financial performance under its existing service delivery and payment models.[4]	Organization reports regularly on financial indicators for monitoring its overall operating margins and financial performance indicators required by key regulatory or funding entities (e.g., UDS, health plans).			Organization monitors key performance indicators and their trends including but not limited to days cash on hand, days in accounts receivable, net collection rates, net income, payer mix, and utilization rates.			Organization compares its key performance indicators to relevant state and local benchmarks to identify and implement strategies for improvement. Organization uses key performance indicators to identify and implement strategies for improvement. Organization staff is able to describe its financial health based on key performance indicators.				Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

9. The organization has experience and capacity to manage performance-based contracts.[4]	Organization has experience negotiating and managing fee for service volume-based and managed care contracts.			Organization has experience negotiating and managing pay-for-performance based contracts, and/or contracts with upside risk only.			Organization has (in house or contracted) experience negotiating downside risk-bearing contracts including experience analyzing the anticipated financial outcomes of such contracts. Organization uses its experiences under past contracts to inform current contracting strategies. Organization uses risk adjustment to support higher payments for higher need patients.				Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

10. The organization has analyzed the relationship between payment reform models and PPS or alternate payment methodology (APM) payment for Medicaid.[4]	Organizational finance, administrative, and clinical leaders understand the basis upon which the organization's current payment model is established (e.g., PPS, APM rate) the costs, and services it includes, and how it relates to actual average per-visit costs.			Organization has analyzed the degree to which payment reform incentives/ payment mechanisms would result in revenue exceeding existing PPS and/or APM rates. Organization has experience navigating state rate setting, managed care reconciliation, and/or scope change processes for PPS or APM when applicable.				Organization has analyzed the impact of proposed APMs on its revenues and operating cash flows.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

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Technology & Data Infrastructure

- The purpose of this domain measures the current data capture & integration capabilities for patient care within the organization.
- Does your practice…
  - Have actionable data that enables your provider/care teams to provide accurate, real-time, and wholistic patient-centered care?
  - Have data systems that talk to each other and produce metrics that are identifiable, actionable, and measurable to the care team/organization accountable for the patient's healthcare?
  - Use technology to enhance efficient care delivery, reduce duplication of effort, and improve communication between the care team and the patient?

Sample Technology and Data Infrastructure Questions

13. The organization's health information technology (HIT) systems allow for use of internal and external data to support population health management.[4]	Organization exchanges information with some Managed Care Organizations (MCO)/ Independent Provider Associations (IPAs) in the form of ad hoc file sharing or static reports for quality measures.			Organization exchanges data with MCO/IPAs to receive eligibility data and some claim types for assigned patients (e.g., receive lab and imaging claims but not professional services or facility claims). Organization sends supplemental files to MCO/IPA for purposes of quality metrics/HEDIS or other specific requests by MCO/IPA.				Organization exchanges data with MCO/IPA and receives eligibility data and all claim types for patients, and this data is integrated into organization's electronic health record or population health systems to inform care in real time.			Don't know/ unsure
	1	2	3	4	5	6	7	8	9	10	DK

14. The organization has in place an automated mechanism for providing real-time notifications to practice staff and care teams regarding patient status (e.g., ED visit, hospital admission and hospital discharge (Admit Discharge Transfer, ADT) data).[11]	Organization does not receive ADT feeds and does not have mechanism for real time notification.		Organization does receive ADT feeds, but notifications are not turned on to support clinical workflows.			Organization does receive ADT feeds with notifications. Clinical workflows do not incorporate ADT notifications, and care teams do not regularly use the information.			Organization has integrated ADT data into EMR/ population health systems and care teams use the information in real time for patient outreach and care management.		Don't know/ unsure
	1	2	3	4	5	6	7	8	9	10	DK

15. The organization has the necessary skills, roles and staff to understand organization's existing data, explore new data sources, and present insights from data.[6]	Organization has limited to no analytics staff; analytic capabilities ebb and flow with staff turnover in informal roles/skills.		Organization has de facto roles for experts within the organization or assigned analyst roles are limited (i.e., part-time, or not the staff member's primary responsibility).		Organization has dedicated and centralized analytics staff exist that participate in cross functional teams and support data driven decision-making; analytics staff may be provided by a support organization (network, consortia, hospital) but not always sufficient for all analytics needs.			Organization has ensured that advanced analytics skills are in place (e.g., research scientist, clinical informaticist, epidemiologist); analysts promote advanced uses of data (e.g., predictive modeling) and build data literacy across the organization.			Don't know/ unsure
	1	2	3	4	5	6	7	8	9	10	DK

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Empanelment & Access

- The purpose of this domain is to:
  - Understand how patients are assigned to a providers or care teams
  - How are patients able to access care

- Empanelment: The extent to which patients are assigned to one provider/care team, which advances powerful therapeutic relationships between patients & providers.
- Access: Empanelment has the ability to increase access, which is how consistently the patient can see their assigned provider/care team when they need to.

Sample Empanelment & Access Questions

Sub-domain: Empanelment

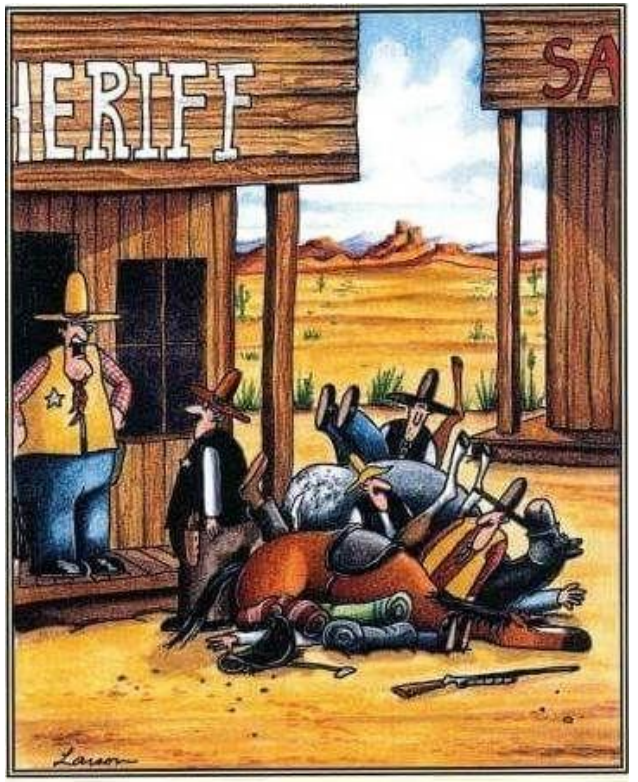
Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

20. Patients[1]	…are not assigned to specific practice panels.		…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.			…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.			…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

21. Patients are encouraged to see their paneled provider and care team[1]	…only at the patient's request.		…by the care team but is not a priority in appointment scheduling.			…by the care team and is a priority in appointment scheduling, but continuity measures are not tracked, and patients commonly see other providers because of limited availability or other issues.			…by the care team and is a priority in appointment scheduling. Continuity measures are tracked and used by the practice, and patients usually see their own provider or care team.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Care Teams & Workforce

- The purpose of this section is to reflect on the care team, including:
  - How does the care team work together to improve patient outcomes
  - Care Teams are organized, roles are clear, workflows are consistently used, there's an approach to regular training
  - Care team members are working to fullest scope of their practice



"And so you just threw everything together? Matthews, a posse is something you have to *organize*."

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Sample Care Team Questions

Care Team & Workforce

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

25. Practice support staff, like medical assistants[7]	…work with different provider(s)every day.		…are linked to provider(s) in dyads but are frequently reassigned and change from day-to-day.			…consistently work with the same provider(s) almost every day, but other clinical and support staff are not integrated into the care team.			…consistently work with the same provider(s) almost every day and their care team includes multidisciplinary roles such as nurses, community health workers, mental health specialists, and administrative personnel.		Don't know/ unsure
	1	2	3	4	5	6	7	8	9	10	DK

26. Care team members[1]	…play a limited role in providing clinical care.		…are primarily tasked with managing patient flow and triage.			… provide some clinical services such as assessment or self-management support.			…perform key clinical service roles that match their abilities and credentials (i.e., work at the top of their license).		Don't know/ unsure
	1	2	3	4	5	6	7	8	9	10	DK

27. Workflows for care teams[8]	…are not documented and/or are different for each person or team.		…are documented but are not used to standardize workflows across the practice.			…are documented and are used to standardize practice.			…are documented, are utilized to standardize workflows, and are evaluated and modified on a regular basis.		Don't know/ unsure
	1	2	3	4	5	6	7	8	9	10	DK

Patient-Centered, Population-Based Care

- The purpose of this section is to understand how care is organized and delivered across patient populations, including to:
  - Use of registry or panel-level data
  - Outreach and engagement
  - Addressing gaps in care
  - Provide care management services for high-risk patients
  - Develop of care plans
  - Involve patients in decision-making and their care plan

Sample Patient-Centered, Population-Based Care Questions

Patient-centered, Population-based Care

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

31. Comprehensive, guideline-based information on prevention or chronic illness treatment[1]	…is not readily available in practice.		…is available but does not influence care.			…is available to the care teams and is integrated into care protocols and/or reminders.			…guides the creation of tailored, individual-level data that is available at the time of the visit.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

32. Registry or panel-level data[1]	…are not available to assess or manage care for patient populations.		…are available to assess and manage care for patient populations, but only on an ad hoc basis and not routinely used for pre-visit planning or patient outreach.			…are regularly available to assess and manage care for patient populations, and for pre-visit planning and patient outreach, but only for a limited number of conditions and risk states.			…are regularly available to assess and manage care for patient populations and are routinely used for pre-visit planning and patient outreach across a comprehensive set of conditions and risk states.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

33. When patients or assigned members are overdue for chronic and/or preventive care but do not come in for an appointment[8]	…the practice makes no effort to contact them and ask them to come in for care.		…the practice may contact them as part of special events or using volunteers, but outreach is not part of regular practice.			…the practice would contact them and ask them to come in for care, but clinical staff may not proactively act on overdue care items without patient-specific orders from the provider.			…the practice will contact them and ask them to come in for care, and clinical staff proactively act on overdue care items (e.g., distribute colorectal cancer screening kits) based on standing orders.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

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Behavioral Health

- The purpose of this section is to understand the availability of behavioral health services, the coordination between physical and behavioral health, and the primary care processes for screening for behavioral health issues in the adult and pediatric patient population.
  - Are behavioral health issues routinely screened for?
  - How are behavioral health needs addressed? Is there visibility on which patients need screening and follow-up?
  - How do Care Team + Behavioral Health Team communicate and develop the care/treatment plan together?
  - Are workflows in place to ensure screening, follow-up and closed-loop referral(s)?

Sample Behavioral Health Questions

Behavioral Health

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

41. **Adult** behavioral health services[1]	…are difficult to obtain reliably.		…are available from behavioral health specialists in the community but are neither timely nor convenient.		…are available from behavioral health specialists in the community and are generally timely and convenient.			…are readily available from behavioral health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement in place. Practice routinely refers patients with higher behavioral health needs to specialty behavioral health providers within the organization or in the community.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

42. **Pediatric** behavioral health services.[1]	…are difficult to obtain reliably		…are available from behavioral health specialists in the community but are neither timely nor convenient.		…are available from behavioral health specialists in the community and are generally timely and convenient.			…are readily available from behavioral health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement in place. Practice routinely refers patients with higher behavioral health needs to specialty behavioral health providers within the organization or in the community.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Social Health

- The purpose of this section is to understand the Practice's commitment to screening and addressing health related social needs.
- This asks about your organizational and care team practices. For example:
  - Do you routinely screen patients for social needs and offer interventions?
  - Do care plans include actions and interventions to address unmet social needs?
  - How does your organization invest in addressing social needs (e.g., develop community partnerships)?

Sample Social Health Questions

Social Health[10]

Each item has a capability listed on the left, please use the response scale that follows to best describe the current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

46. Organization has leadership buy-in and commitment to identifying and addressing patients' social needs.[11]	In general, leaders express that addressing patients' social needs is "nice to have" or an optional add-on to our primary work of delivering clinical care.		Leaders generally express commitment to addressing patients' social needs but do not provide adequate resources.		Leaders generally express commitment to addressing patients' social needs and provide some resources but resources may not be adequate.			Leaders at every level (C-suite, departmental, people managers, etc.) express commitment to addressing patients' social needs and provide adequate resources. Patients' social needs are incorporated into strategic priorities and addressing social needs is included in the organization's model of care. Staff receive training and support to address patients' social needs.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

47. Organization screens patients to understand unmet social needs.[11]	Organization does not consistently screen patients for unmet social needs but is aware of and documents patients' social needs when they proactively report specific needs.		Organization screens patients for one or more unmet social needs in an ad hoc, inconsistent way, which may be required for a specific grant or program.		Organization has an established social needs screening or assessment tool/process, which is consistently used for certain sub-sets of the patient population (e.g., pediatrics, patients with chronic conditions, etc.) or for specific social needs (e.g., food, housing).			Organization has an established universal screening or assessment tool/process which comprehensively identifies patients' specific, addressable, and high impact social needs. Roles and workflows for screening are clearly defined and understood.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

48. Care teams adapt care plans (e.g., medications, action plans, referrals) based on an understanding of patients' social needs.[11]	Social needs data is unavailable for addressing patient need.			Social needs data is available to clinical teams at the point of care but not regularly used to change care plans.			Social needs data is available to clinical teams at the point of care and is regularly used to modify care plans as appropriate in partnership with patients and families.				Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

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Time for a poll!

How prepared do you feel to complete the PhmCAT?

Next Steps

- ❑ Identify the team members who will complete the PhmCAT.
- ❑ Starting April 1st, the PhmCAT can be completed in the EPT deliverables portal.
  - ❑ Respondents will submit their responses individually.
  - ❑ In early April, please make sure that everyone can access the portal!
- ❑ The PhmCAT is due **May 1st, 2024** from all respondents at your practice.
- ❑ The Learning Center will provide practice-level reports back to practices.

Q&A