How Can Care Management Improve Patient Outcomes? Focus on Risk Stratification

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**Clinical Care Management Population of Focus**

- **“Rising Risk” Patients**
- **Care Management Highest Risk**

**Clinical Care Management Continuum of Care**

1. **Identify Highest Risk Patients**
2. **Intake Assessment & integrated Care Plan Development**
3. **Implement Care Plan & CCM Interventions**
4. **Ongoing Assessment, Evaluation & Updating of Care Plan**
5. **Evaluation/Discharge from CCM Services**

**PRACTICE-BASED RISK STRATIFICATION APPROACHES**

**Why Clinical Care Management?**
- Half of US health care dollars are spent on 5% of the population
- Annual medical expenses for patients with both chronic and behavioral health conditions are 46% more than that of patients who have chronic medical conditions only
- The top 10% of health care users consume 33% of ambulatory and approximately 50% of inpatient services
- Overall, care integration helps to:
  - Enhance holistic, patient-centered care
  - Improve overall health outcomes
  - Increase efficiency and access to care
  - Minimize stigma and discrimination
  - Reduce costs

**Does Clinical Care Management Work? YES!**

- PCMH practices had significantly reduced costs and utilization for the highest risk patients, particularly with respect to inpatient care
- Reduced costs
- Reduced hospital admissions and stays
- Higher patient satisfaction
- Reduction of depression symptoms
- Improvements in blood glucose control
- Improved health behaviors (e.g., exercise)

**Massachusetts Primary Care Reform Initiatives**

- **Primary Care Payment Reform (PCPR)**
  - Multi-payer, statewide initiative
  - Sponsored by Massachusetts Health & Human Services; legislatively mandated
  - 46 participating practices
  - 3-year demonstration: March 2011 - March 2014
  - Included payment reform and technical assistance

**Primary Care Risk Stratification**

- Helps a practice efficiently, systematically, and statistically better understand patients and their risk for future costs
- Provides information about which members may need clinical care management the most
- Employs utilization information such as hospitalization and ED use

**Simplest Approach**

- Ask providers which patients they are most concerned about – which patients they consider most at risk for:
  - Hospitalization/ED utilization
  - Sentinel events
  - Adverse outcomes
- Each provider identifies top 3-5% of their panel, or specified number of patients based on Clinical Care Management capacity

**Some Criteria to Consider:**

- Stratify patients based on:
  - Disease severity
  - Co-morbidities
  - Self-care deficits
  - Poly-pharmacy
  - Behavioral health issues

**Example of a Practice-Based Risk Stratification Tool: Patient Acuity Rubric**

- Single-payer
- Massachusetts Medicaid’s fQAP alternative payment program that will enable the move from fee-for-service reimbursement towards alternative payment models
- Improve access, patient experience, quality, and efficiency through care management and coordination and integration of behavioral health
- 10 participating practice organizations, approximately 50 sites
- 3-year project March 2013 - March 2016

**Example of a Payer-Based Risk Stratification Tool: DxCG High Risk Ranking**

- Age
- Gender
- Disability
- Relative to Practice Population
- Disease Conditions
- Relative Costs
- Relative Costs are based on ranking 1 yr.

**Advantages/Limitations of Payer Member Reports**

- **Advantages**
  - Last primary care practice visit within six months
  - ED and hospital utilization with diagnoses
  - Most recent contact information
- **Limitations**
  - Patients listed may not be priority of provider and team
  - Month lag with utilization data
  - No substance abuse utilization and diagnoses

**Workflow Example – Combining Payer & Practice-based risk stratification data**

- Generate high risk practice list (level of complexity will vary depending on practice capacity)
- Compare practice high risk list with payer high risk list
- Generate merged list to reflect only patients common to both lists
- If no matches, use practice list to identify patients who have not received treatment in the last six months. Outreach to those patients and during visit, perform assessment and/or use payer high risk list

- When matches exist, integrate payer data with EMR data (AV, ED, utilization, diagnoses etc.) for care team review and determination of care plan.