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

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PROBLEM STATEMENT/BACKGROUND
Providing Clinical Care Management to the highest risk, most complex and costly patients is very important for primary care practices recognized as a Patient Centered Medical Home (PCMH). This is a new service for most primary care practices. Identifying patients who would most likely benefit from Clinical Care Management services is an important first step. This will help direct the appropriate resources and interventions to mitigate risk and improve outcomes for individual patients and help practices achieve their PCMH goals.

AIMS
• Identify the key elements for practice-based Risk Stratification methods
• Identify approaches for measuring and evaluating effectiveness of Risk Stratification and Clinical Care Management at the practice level

Why Clinical Care Management?
• Half of US health care dollars are spent on 5% of the population\(^1\)
• Annual medical expenses for patients with both chronic medical and behavioral health conditions are 46% more than that of patients who have chronic medical conditions only\(^2\)
• The top 10% of health care users consume 33% of ambulatory and approximately 50% of inpatient services\(^3\)
• Overall, care integration helps to:\(^3\)
  – 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 has significantly reduced costs and utilization for the highest risk patients, particularly with respect to inpatient care\(^4\)
• Reduced costs\(^5\)
• Reduced hospital admissions and stays\(^6\)
• Higher patient satisfaction\(^7\)
• Reduction of depression symptoms\(^8\)
• Improvements in blood glucose control\(^9\)
• Improved health behaviors (e.g., exercise)\(^10\)

Massachusetts Primary Care Reform Initiatives
Massachusetts Patient Centered Medical Home Initiative (MA-PCMH)
• 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 Payment Reform (PCPR)
• Single-payer
• Massachusetts Medicaid’s fiscally 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 2014 - March 2017

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

Clinical Care Management Population of Focus

Care Coordination

“Rising Risk” Patients

Care Management

Highest Risk

Why Clinical Care Management?

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

Care Coordination & Clinical Care Management Overlap & Differences...

Clinical Care Management = Care Coordination +

• Care Plan development
• Frequent contact with patient
• Clinical assessment & monitoring
• Medication reconciliation
• Intensive medication management
• Self management support
• Patient teaching
• Development & implementation of the Integrated Care Plan
• Bi-directional communication with treating professionals

PRACTICE-BASED RISK STRATIFICATION APPROACHES

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

Clinical Care Management Continuum of Care

Tracking, Coordinating & Managing Care of Highest Risk Patients across the “Continuum”

Reference
46.7

63.3

Risk Stratification in the MA PCMH

• PCMH practices prospectively generated a list of patients who might benefit from additional care using clinical measures and utilization information such as hospitalization and ED use
• Some practices developed risk stratification tools that included other practice-specific conditions of interest:
  – Co-morbidities
  – Availability of family/social support mechanisms
  – Poly-pharmacy
  – Behavioral health issues

Risk Stratification in the PCPR

• PCPR participating practices provided a payer-generated list of patients for whom additional care – either Care Coordination and/or Clinical Care Management services – is expected
• Practices also receive a list of patients who are considered high risk based payer algorithm
• Practices conduct retrospective risk assessment on this list
  – Compare practice-based list with the two lists provided
  – Generate a list of common patients
    – Integrate data sources for care team review and determination of care plan
  – If no common patients:
    – Use practice based list to identify patients who have not received treatment in the last six months & initiate outreach
    – Use payer high risk list to exclusively guide service delivery

Clinical Care Management Performance Metrics

• Change in patient acuity rubric score
  – Individual
  – For cohort over time
• Number of high risk patients in active Clinical Care Management
• Reduction in avoidable ED visits
• Reduction in avoidable inpatient admissions
• Number of patients in care management who are achieving individual patient-centered goals

Results: Care Coordination/Care Management Measures

Change over Time in MA PCMH

SUMMARY

Risk Stratification is the foundational step in establishing delivery of practice-based clinical care management services.
• Allows practices to identify patients who would benefit most from clinical care management services
• Allows creation of a High Risk Registry based on practice and payer data and identification of patients who need integrated care plans
• Helps identify resources needed to support patients and families and to plan new workflows related to this process
• Helps practices assess effectiveness by developing applicable process and outcome measures that support patient and practice Clinical Care Management goals

REFERENCES

\(^1\) Available at http://www.kff.org/medicaid/8081.cfm.


\(^4\) Available at http://www.chpr.umassmed.edu/.


\(^6\) Available at http://www.chpr.umassmed.edu/.

\(^7\) Available at http://www.chpr.umassmed.edu/.

\(^8\) Available at http://www.chpr.umassmed.edu/.

\(^9\) Available at http://www.chpr.umassmed.edu/.

\(^10\) Available at http://www.chpr.umassmed.edu/.