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

Joan Johnston  
University of Massachusetts Medical School

Judith L. Steinberg  
judith.steinberg@umassmed.edu

Sai Cherala  
University of Massachusetts Medical School

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**Care Plans for Highest Risk Patients**

**Why Clinical Care Management?**
Care Management services are an important first step. This will help complex and costly patients in very important for primary care.

- Providing Clinical Care Management to the highest risk, most vulnerable patients.
- Reduced hospital admissions and stays.
- Reduced inpatient care.
- Ambulatory and approximately 50% of inpatient services.
- Annual medical expenses for patients with both chronic conditions.
- Minimize stigma and discrimination.
- Increase efficiency and access to care.
- Enroll patients into CCM.

**Includes payment reform.**

**3-year demonstration:**
- March, 2014 - March, 2017
- Approximately 50 sites

**Example of a Payer-Based Risk Stratification Tool:**

- **DxCG High Risk Ranking**

**Clinical Care Management Population of Focus**

**Clinical Care Management Continuum of Care**

**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 medical 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 have 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**

**Massachusetts Primary Care Reform and Innovation (PCRI)**
- Multi-year, 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.

**Clinical Care Management Population of Focus**

**Clinical Care Management Continuum of Care**

**Practice-Based Risk Stratification Approaches**

**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 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**

**Example of a Payer-Based Risk Stratification Tool:**

- **DxCG High Risk Ranking**

**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.

**Risk Stratification in the MA PCMI**

- 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 integrated other practice-specific conditions of interest.
  - Co-morbidities.
  - Self-care deficits.
  - Poly-pharmacy.
  - Behavioral health issues.

**Risk Stratification in the PCPR**

- PCPR participating practices are 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 on payer algorithm.
- Practices conduct retrospective risk assessment on this list— compare practice-based list with the two lists provided and 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 exclusively to 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.

**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**