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

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**Care Coordination & Clinical Care Management**

**Clinical Care Management Population of Focus**

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

**Clinical Care Management Continuum of Care**

- **Tracking, Coordinating & Managing Care of Highest Risk Patients across the “Continuum”**
- **Intake Assessment & integrated Care Plan Development**
- **Implement Care Plan & CCM Interventions**
- **Ongoing Assessment, Evaluation & Updating of Care Plan**
- **Evaluation/ Discharge from CCM Services**

**Care Coordination**
- Track & assist patients across care settings
- Coordinate care services
- Timely follow-up of ED visits & hospital discharges
- Exchange of information across care settings
- Smooth transitions of care
- Referral & information sharing protocols – Primary Care & Behavioral Health Providers
- Community service referrals

**Clinical Care Management = Care Coordination +**
- Care Plan development
- Frequent contact with patient
- Clinical assessment & monitoring
- Medication reconciliation
- Intense 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**

**Primary Care Risk Stratification**
- Helps a practice efficiently, systemically, and statistically better understand patients and their risk for future costs
- Provides information about which members may need clinical care management the most
- Employ utilizes 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**

**Risk Stratification in the MA PCMH**
- **PCMH practices prospectively generated a payer-generated 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
  - 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**
- **Practice conducts 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 and 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

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

- **Health Status**
  - Age
  - Gender
  - BMI
  - Disability

- **Relative to Practice Population**

- **Risk Rank**

- **Disease Conditions**

- **Recent Costs**

- **Cost data are based on rolling 1 yr.**

- **Relative to Practice Population**

- **RISK**

- **Disease Conditions**

- **10 major diagnosis group (no substance abuse)**

**Advantages/Limitations of Payer Member Reports**

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last primary care visit within six months</td>
<td>Patients listed may not be priority of provider and team</td>
</tr>
<tr>
<td>ED and hospital utilization with diagnoses</td>
<td>Month lag with utilization data</td>
</tr>
<tr>
<td>Most recent contact information</td>
<td>No substance abuse utilization and diagnoses</td>
</tr>
</tbody>
</table>

**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

**When matches exist, integrate payer data with EMR data** (A1C, BP, ED utilization, diagnoses etc.) for care team review and determination of care plan.

**SUMMARY**

Risk Stratification is the foundational step in establishing delivery of practice-based clinical care management services.
- Allows practices to identify patients who might 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**

- 8 Sai Cherala, MD, MPH
- 9 Joan Johnston, RN
- 10 Dai Johnston, MD, MPH

- 11 Massachusetts Primary Care Reform Initiatives
- 12 Multi-payer, statewide initiative
- 13 Sponsored by Massachusetts Health & Human Services, legislatively mandated
- 14 46 participating practices
- 16 Included payment reform and technical assistance

- 17 Primary Care Payment Reform (PCPR)
- 18 Single-payer
- 19 Massachusetts Medicaid’s flagship alternative payment program that will enable the move from fee-for-service reimbursement towards alternative payment models
- 20 Improve access, patient experience, quality, and efficiency through care management and coordination and integration of behavioral health
- 21 10 participating practice organizations, approximately 50 sites
- 22 3-year project March, 2014 - March, 2017