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

**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**

**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 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**

- Generate high risk practice list (level of compliance will vary depending on practice capacity)
- Compare practice high risk list with payer high risk list.

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

- **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 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 PCMIH**

- PCMIH 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
  - Availability of family/social support mechanisms
  - 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 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/Management Measures**

<table>
<thead>
<tr>
<th>Change over Time in MA PCMIH</th>
<th>Average Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>63.3</td>
</tr>
<tr>
<td>Time 1</td>
<td>56.5</td>
</tr>
<tr>
<td>Time 2</td>
<td>36.1</td>
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</tbody>
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**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**