



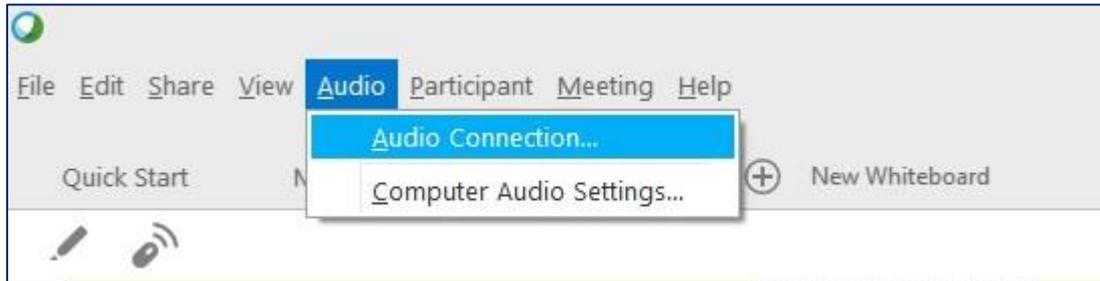
POPULATION MANAGEMENT RISK STRATIFICATION PART 1

December 20, 2017

How would you caption this?

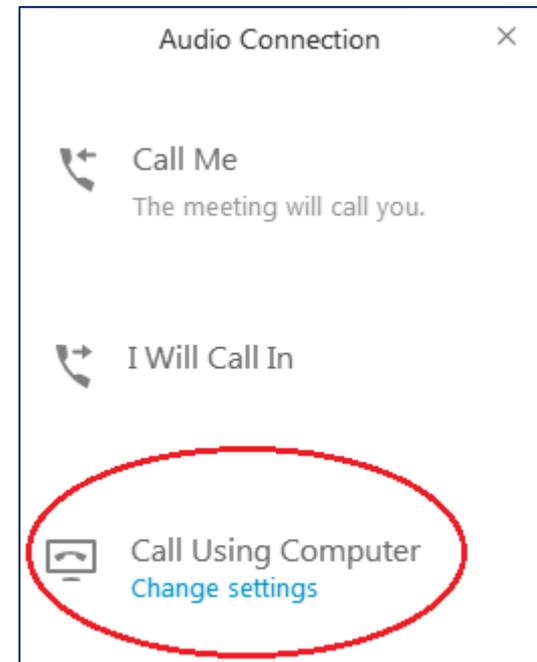


Audio Connections



If you are not hearing any sound, please select “call using your computer” from Audio tab

NOTE: If you are hearing an echo, try lowering the volume on your computer or wearing headphones



Setting the Foundation

Today's Agenda:

10:00-11:00 AM

- Introduction to today's webinar
- Population Management & Risk Stratification
- Evolution of the NCQA PCMH Guidelines
- How PCMH helps you stratify and manage your patient population's health
- Facilitated Discussion
 - Best Practices, Challenges and Novel Ideas

Introduction to the Webinar

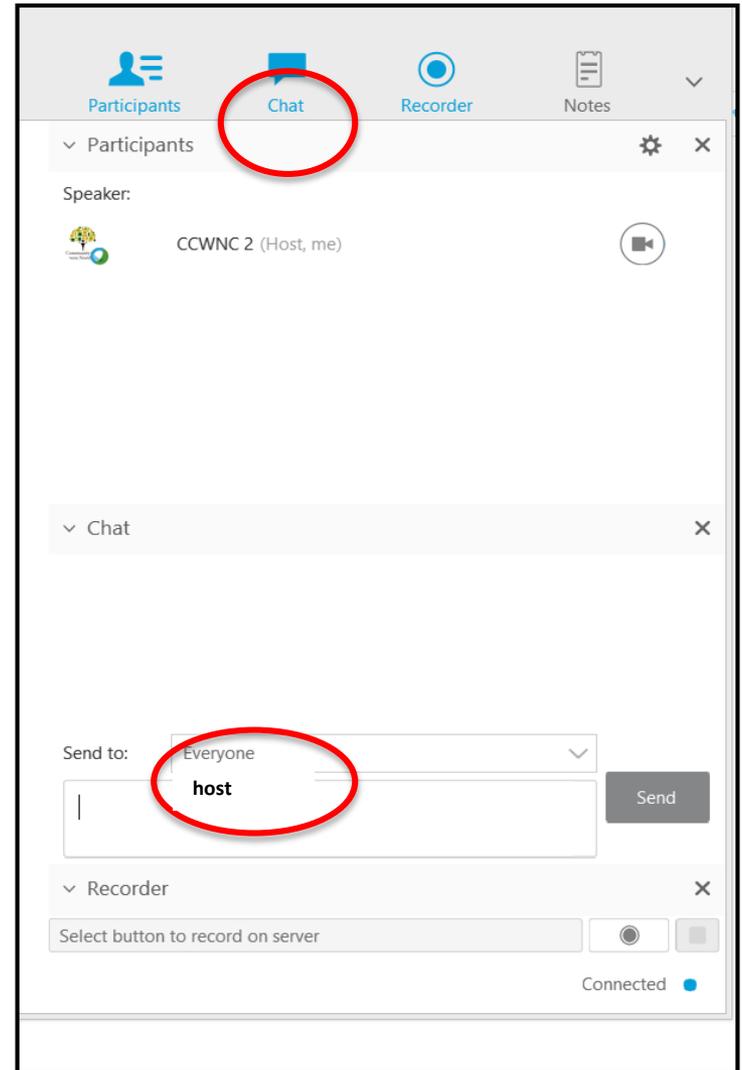
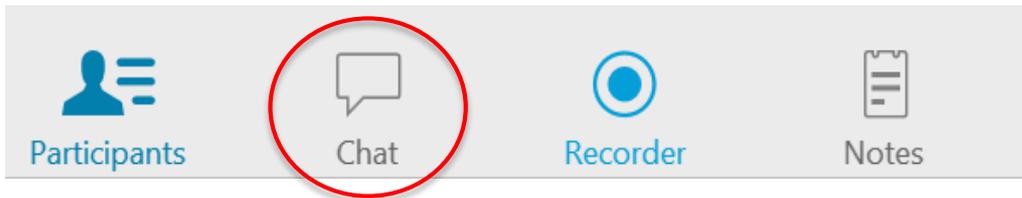
Chat box during the presentation:

➤ Send to the Host

- BEST PRACTICES
- CHALLENGES
- NOVEL IDEAS
- QUESTIONS

Example:

- “NOVEL IDEA – STRUCTURED COMMUNICATION: My practice meets at the end of the day, rather than in the morning”



Quick Review: PCMH 2017 Terminology

6 Concepts

TC : Team-Based Care and Practice Organization

KM : Knowing and Managing your Patients

AC : Patient-Centered Access and Continuity

CM : Care Management and Support

CC : Care Coordination and Care Transitions

QI : Performance Measurement and Quality Improvement

Quick Review: PCMH 2017 Terminology

Today's Concepts:

KM : Knowing and Managing your Patients

CM : Care Management and Support

Risk Stratification: Relevant PCMH 2017 Criteria

- **KM1 (Core):** Documents an up-to-date problem list for each patient with current and active diagnoses
- **KM2 (Core):** Comprehensive health assessment
- **KM5 (1):** Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners
- **KM6 (1):** Identifies the predominant conditions and health concerns of the patient population
- **KM7 (2):** Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data
- **KM8 (1):** Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials
- **KM9 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population
- **KM10 (Core):** Assesses the language needs of its population

Risk Stratification: Relevant PCMH 2017 Criteria

- **CM1 (Core)** Considers the following in establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):
 - A. Behavioral health conditions
 - B. High cost/high utilization
 - C. Poorly controlled or complex conditions
 - D. Social determinants of health
 - E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver
- **CM2 (Core)** Monitors the percentage of the total patient population identified through its process and criteria.
- **CM3 (2)** Applies a comprehensive risk- stratification process to entire patient panel in order to identify and direct resources appropriately.

Why Stratify a Population?

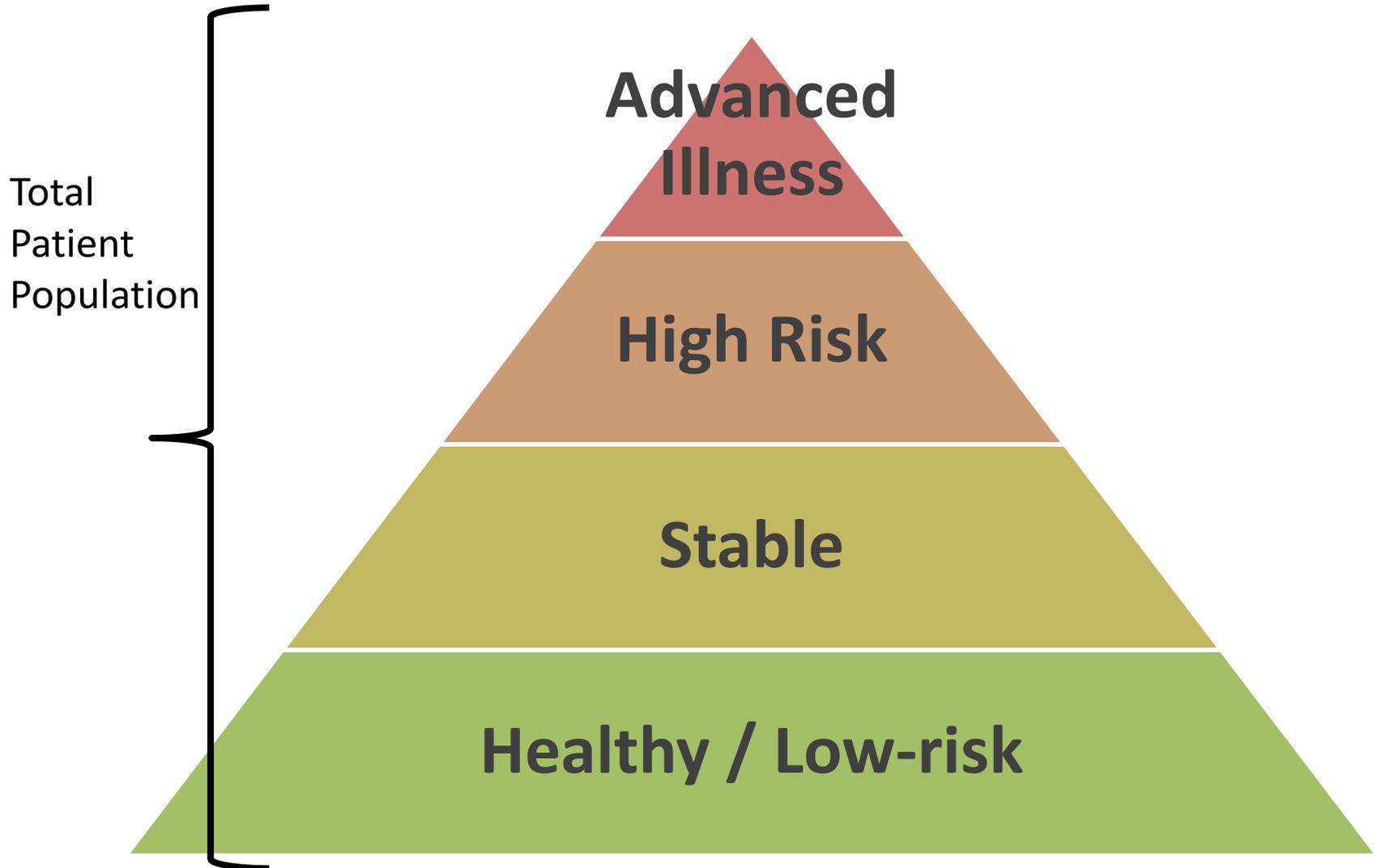
1 Find out who your patients are

2 Understand what they need:

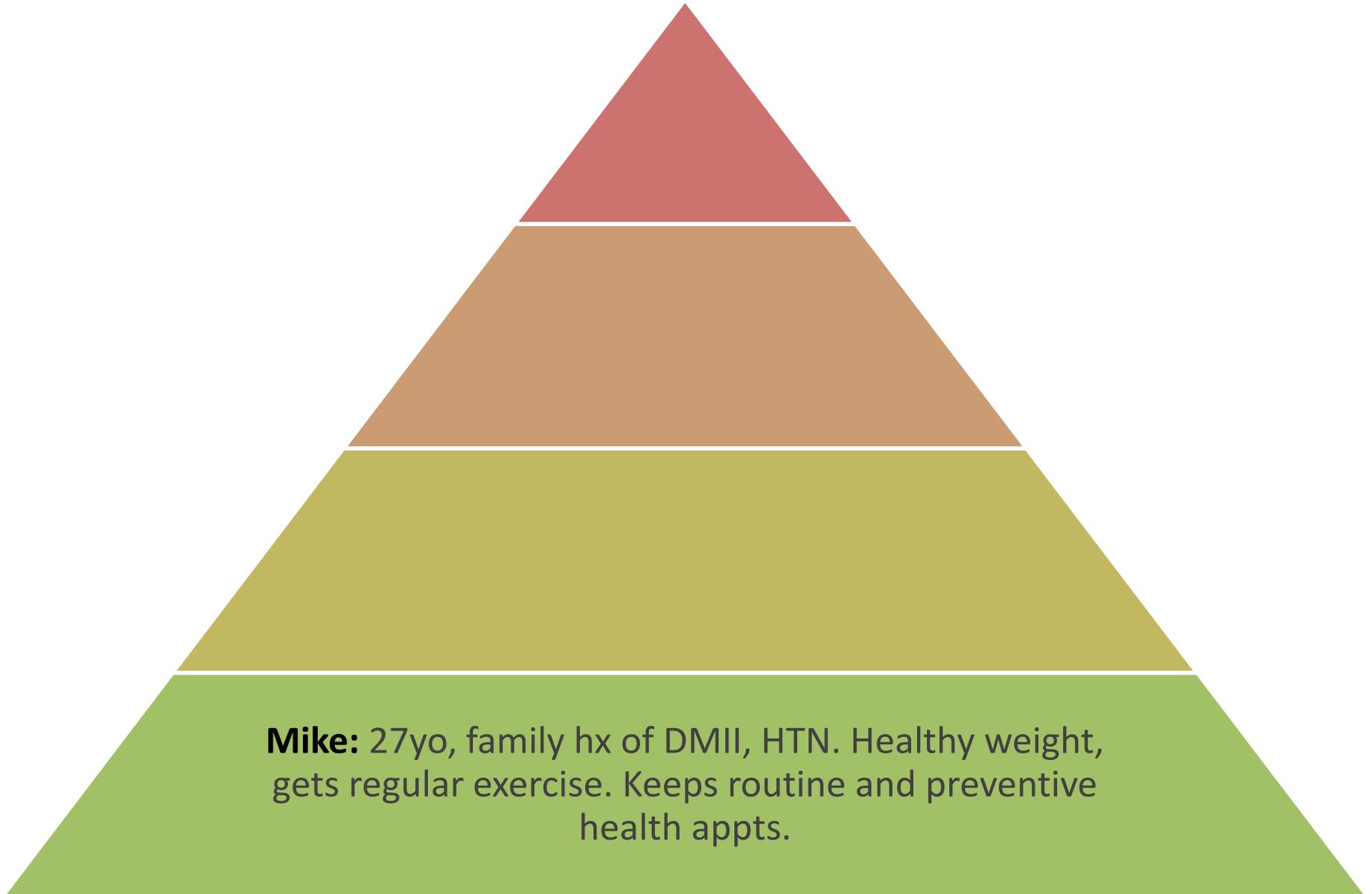
- Evidence-based preventive care
- Access to appropriate resources



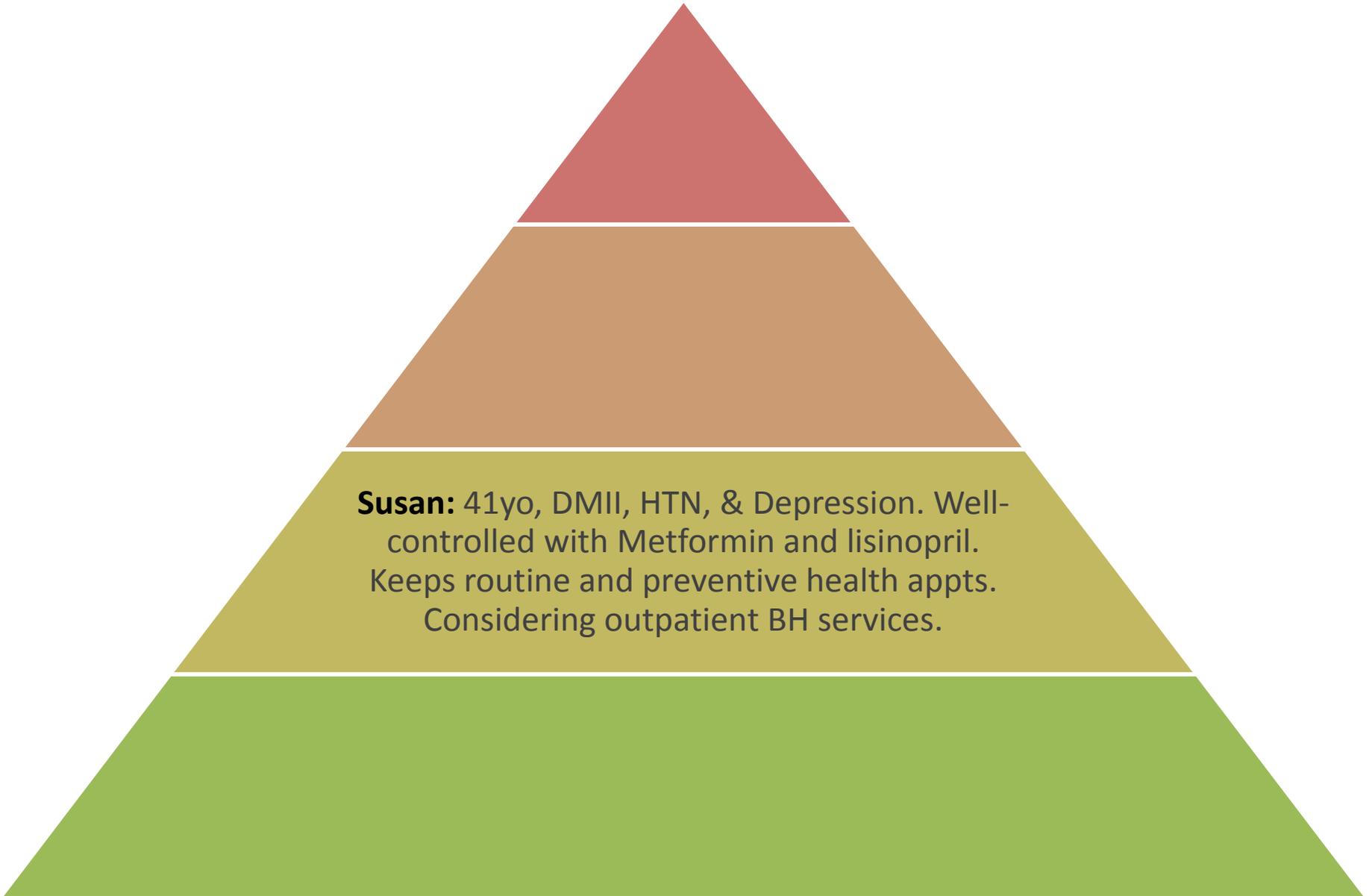
Population Health



Assessing Population Health

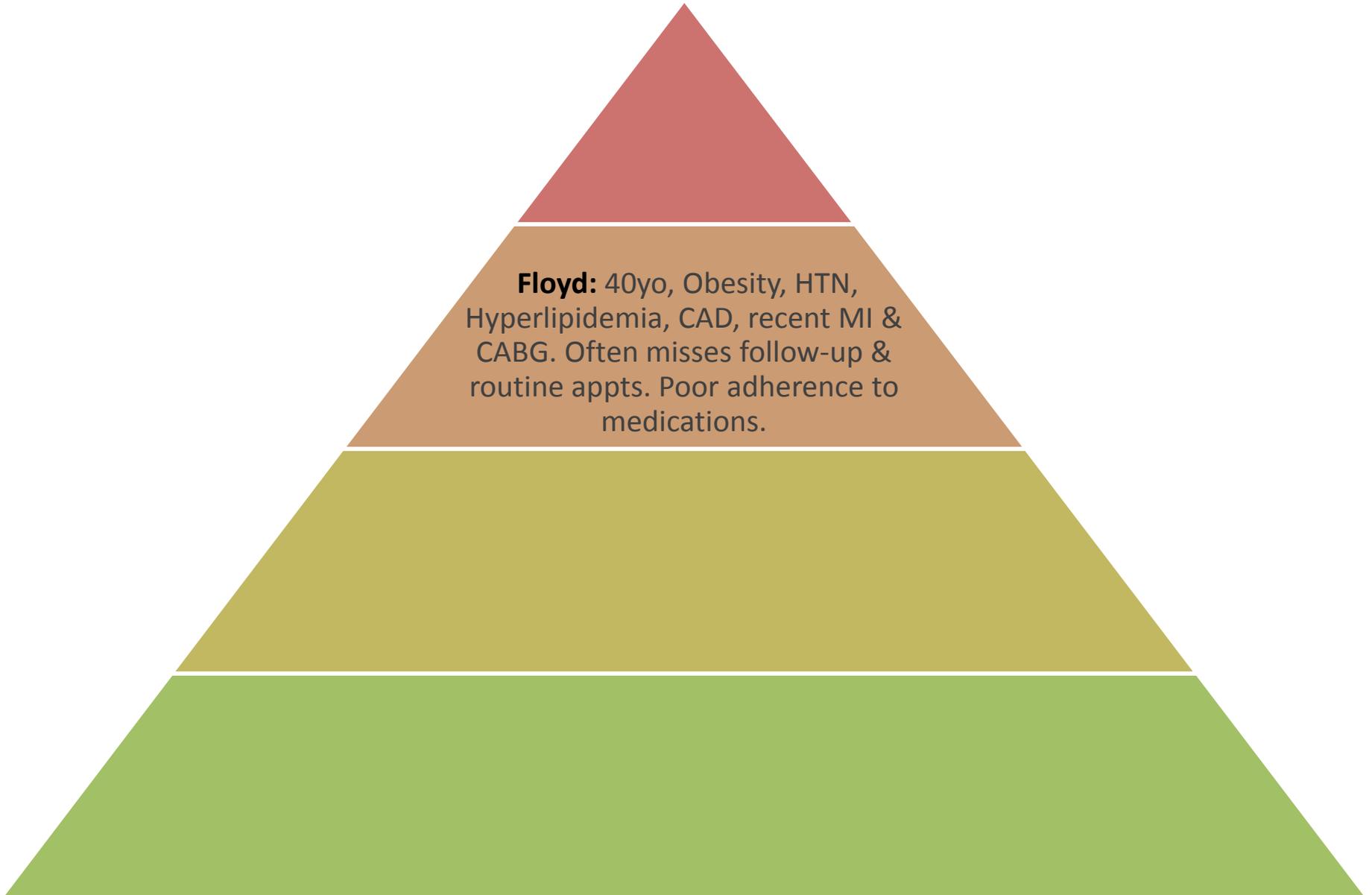


Assessing Population Health

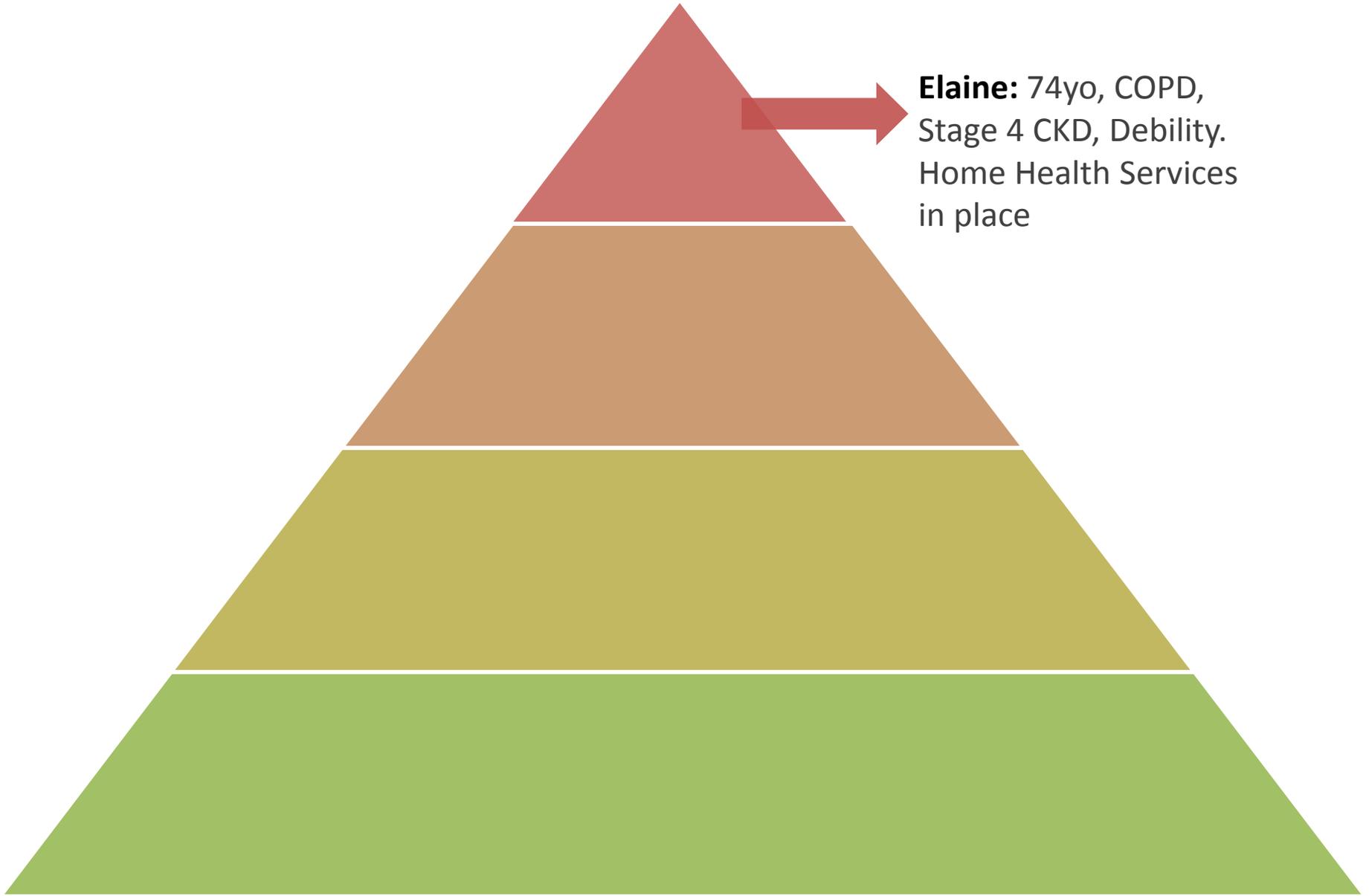


Susan: 41yo, DMII, HTN, & Depression. Well-controlled with Metformin and lisinopril. Keeps routine and preventive health appts. Considering outpatient BH services.

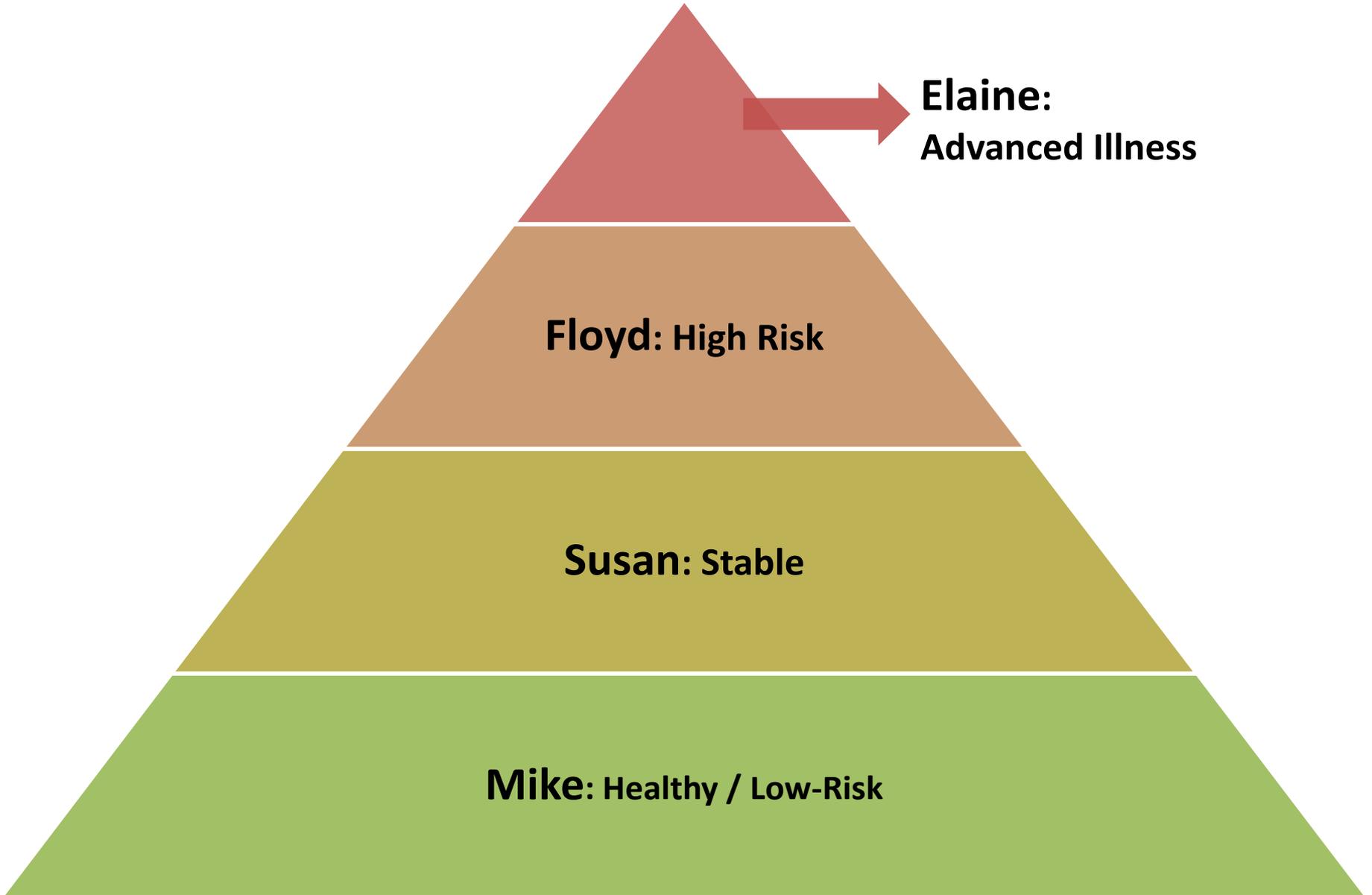
Assessing Population Health



Assessing Population Health



Assessing Population Health



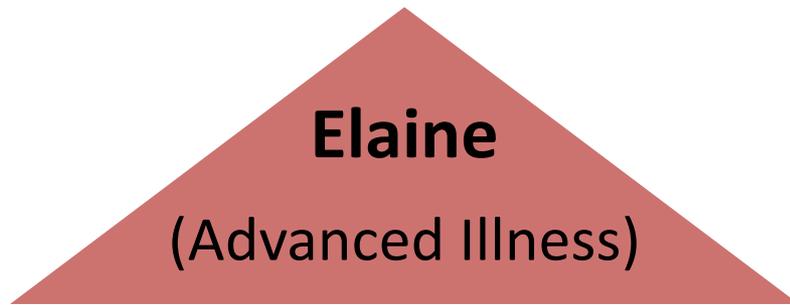
Finding Opportunity to Make an Impact

Support Health Promotion & Prevention Planning

Susan (Stable)

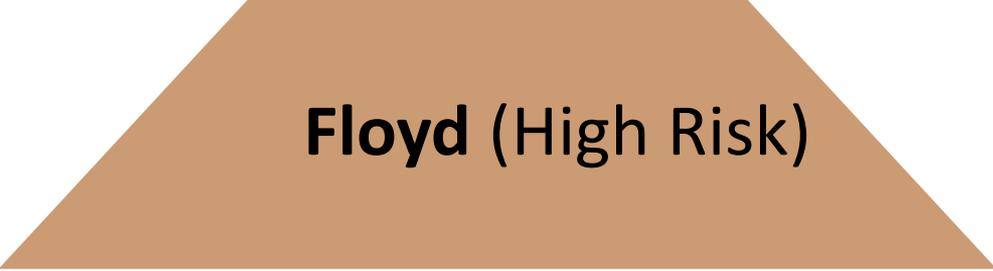
Mike (Healthy)

Finding Opportunity to Make an Impact



CAP Services & other resources are in place, coordinated by Primary Care & Staff

Finding Opportunity to Make an Impact

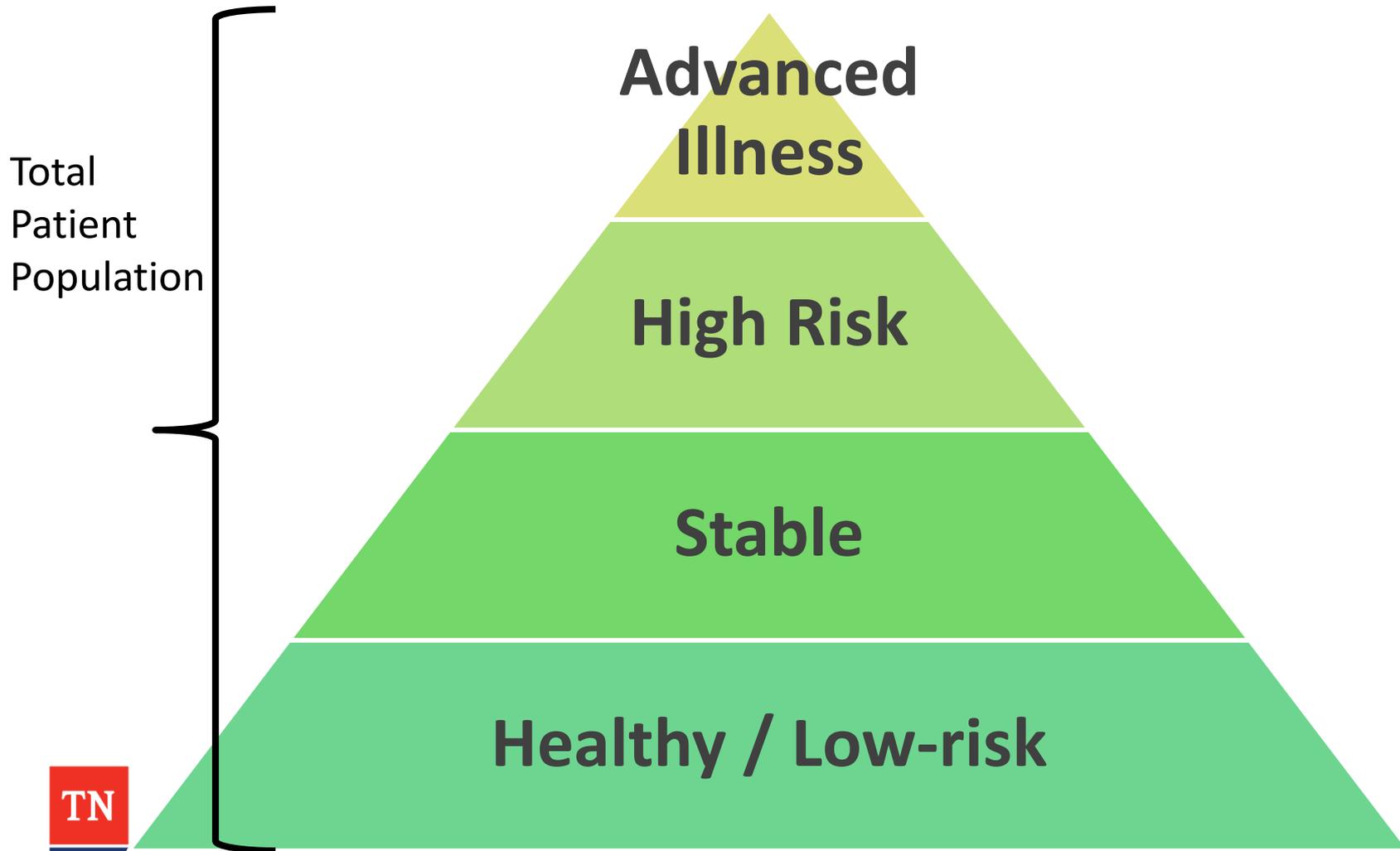


Floyd (High Risk)



**Care Planning
Care Management
Goal-setting
Education
Self-Management Support**

Population Health



What Criteria Should Be Used to Stratify Your Patients?



NCQA PCMH: 2011 to 2017

2011

- 3 important conditions: provide goal-setting & med mgmt
- MU Stage 1

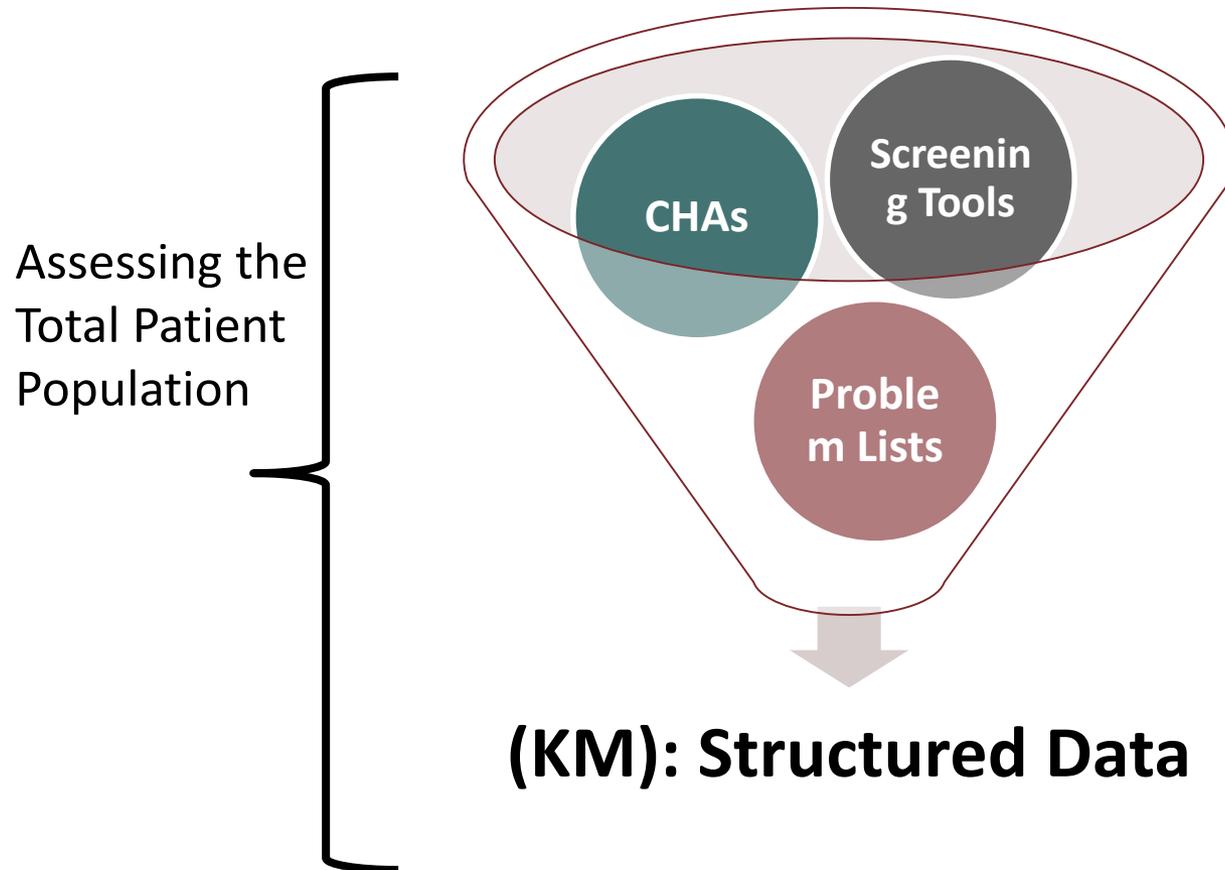
2014

- High-Risk Patients – Perform goal-setting, med mgmt & CHA
- More integration of Behavioral Health
- Focus on Social Determinants of Health
- MU Stage 2 (modified)

2017

- Stratifying entire patient population, including High Risk Patients
- Clinical Quality Measures (eCQMs)

Knowing Your Patients (KM)



Start with Good Data

KM1 (Core): Document an up-to-date problem list for each patient with **current and active diagnoses**

Or document **KM6 (1):** Identifies the **predominant conditions** and **health concerns** of the patient population.

How can you achieve this?

- Apply a process by which problem lists are updated at each visit
- Utilize EMR to capture list of all dxs for all active pts ; sort to find most common dxs in the population
- Use practice management software to find claims-based data that shows predominant health concerns?

Comprehensive Health Assessment

KM2 (Core): Comprehensive Health Assessment *(all items required)*

- A. Medical history of patient and family
- B. Mental health/substance use history of patient and family
- C. Family/social/cultural characteristics
- D. Communication needs
- E. Behaviors affecting health
- F. Social Functioning *
- G. Social Determinants of Health *
- H. Developmental screening using a standardized tool
(for Pediatric population under 30 months of age)
- I. Advance care planning *(NA for pediatric practices)*

How can you achieve this?

- Interview Patients during relevant visits at established intervals
- Utilize the Portal to gather information
- Use waiting room Forms or Tablets to collect information
- Develop a standard for reviewing this information at wellness visits

More Data...

KM10 (Core): Assess the **language needs** of the population

KM8 (1): Evaluate patient population **demographics / communication preferences / health literacy** (*to tailor development and distribution of patient materials*)

KM9 (Core): Assess the **diversity** (*race, ethnicity, and one other aspect of diversity*) of its population

KM5 (1): Assess **oral health needs** and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners

Comprehensive Risk-Stratification Process

CM3 (2): Applies a comprehensive risk- stratification process to entire patient panel in order to identify and direct resources appropriately.

((NOTE: The evidence for this Criteria is a report))

Other ways to achieve this?

- Utilize statistical algorithms such as
 - AAFP Risk-Stratification Model
 - MCO-assigned Risk Levels
- Use screening tools such as
 - PAM
- Care Coordination Tool
 - Provides risk scores for entire TennCare population

Computing an Individuals Risk Score

- A Medicaid individual's risk score in the CCT is the additive sum of:
 - An age/sex base rate
 - Risk weights for each separate diagnosis category
 - These weights are triggered by a single occurrence of any diagnosis included in the category in a year
 - Weight is only applied for most costly diagnosis category in a hierarchy
 - Additional weight that may be included for the interaction of two diagnosis categories where significant synergies have been identified
- Patient risk scores in the Care Coordination Tool are calculated using the Chronic Illness and Disability Payment System (CDPS) risk adjustor:
 - A validated tool created by the University of California, San Diego
 - Used by multiple states' Medicaid programs as well as private insurers
 - CDPS works by adding risk across a variety of disease categories to calculate a risk score for each individual patient
 - Risk categories are determined based on a stratification of the risk scores into the critical, high, medium-high, medium and low risk categories
- More information about CDPS can be found at <http://cdps.ucsd.edu>

CCT Screenshot

The screenshot displays a web application interface for Altruista Health. The main content area is titled 'My Members' and shows a list of members. A 'Risk Chart' overlay is visible, showing a pie chart with a green segment representing 'No Risk Level - 418 - 78.42%'. The table below the chart lists the following members:

	Last Name	First Name	Altruista ID	DOB	Risk	Risk Score	Health Plan	THL Status	Date/Attribute	SSN
+	ABEL	RONALD	68400646974	1989-01-28	N/A	N/A				
+	ABEL	JASON	10631778746	1968-01-07	N/A	N/A				
	ABEL	WILLIAM	07351180156	2020-03-02	N/A	N/A				
	ABEL	SIMON	73876487079	1983-01-06	N/A	N/A				
+	ABEL	ELIZABETH	79897097323	1982-06-01	N/A	N/A				
	ABEL	BETTY	27919430701	2026-11-18	N/A	N/A				
+	ANDERSON	FIONA	23494143709	2017-09-09	High	2.182	BCBS	Active	04/16/2017	468795219
	ANDERSON	CHERYL	87925034325	1964-09-23	Low	0.509	TN Select	Active	04/16/2017	080012756
	ANDERSON	DONNA	02022229090	2002-01-26	Critical	4.189	United	Active	04/16/2017	476637989
	ANDERSON	MICHELLE	99368013548	1937-09-11	High	3.169	BCBS	Active	04/16/2017	861255406
+	ANDERSON	EDWARD	14636584602	1970-01-22	Low	0.509	United	Active	04/16/2017	196751969
	ANDERSON	MARK	31855450341	2006-09-11	N/A	N/A	United	Active	07/31/2017	894335606

CCT continued

Member Summary

Primary Phone : Not Available Care Manager : Not Assigned Service Interruption : Not Available

RISK SCORE 2.561

KIMBERLY J MARTINEZ-16332855668 PCP : No Community Care Org : Not Available

Member Medical Info Visits Diagnosis Medications Health Indicators Appointments

Primary Medical Conditions:	Not Available	Primary Behavioral Conditions:
Additional Medical Health Info:	Not Available	Additional Behavioral Health Info:
Secondary Medical Conditions:	Not Available	Secondary Behavioral Conditions:
Height:	Not Available	Weight
Communication Impairment:	Not Available	Care Manager:
Programs:	MTM - High CDPS, THL	Service Interruption:
Evacuation Zone:	Not Available	

▶ Allergies & Sensitivities

▶ Vaccination details

▶ Preventive screening details

11:54 AM 12/6/2017



CCT Information

Altruista Health ... Care Coordination Tool

Secure | <https://www.tn.gov/tenncare/article/care-coordination-tool>

TN Division of TennCare

Members / Applicants Providers TennCare Kids Policy & Guidelines Long-Term Services & Supports Newsroom Contact Us

Health Care Innovation

- Episodes of Care
- Long-Term Services and Supports

Primary Care Transformation

- Care Coordination Tool**
- Patient-Centered Medical Homes (PCMH)
- Tennessee Health Link
- Stakeholder Presentations

Care Coordination Tool

Tennessee has developed a shared Care Coordination Tool that allows providers participating in the Patient Centered Medical Home (PCMH) and Tennessee Health Link programs to be more successful in the state's new payment models. This tool was built and implemented in partnership with Altruista Health.

The tool identifies and tracks the closure of gaps in care linked to quality measures. It also allows providers to view their member panel and members' risk scores, which facilitates provider outreach to members with a higher likelihood of adverse health events. The tool enables users to see when one of their attributed members has had an admission, discharge, or transfer (ADT) from a hospital or emergency room and track follow-up actions. While the tool does not presently contain ADT feeds from every hospital in Tennessee, the State is working with the Tennessee Hospital Association to include state-wide coverage by the end of 2017. Furthermore, the tool provides claims-based medication information about members for providers to view.

The Care Coordination Tool was piloted with nine organizations from across Tennessee in the summer of 2016. Based on feedback from providers, additional enhancements and customization were made to the tool prior to launch, and additional enhancements are scheduled for future releases on an ongoing basis.

The Care Coordination Tool was rolled out to PCMH and Tennessee Health Link providers in February 2017. The tool will be made available to additional Tennessee providers who are participating for the first time in the State's PCMH and Tennessee Health Link programs in 2018. In the future, the State plans to expand access to the Care Coordination Tool to any primary care providers who wish to participate.

- > Key Documents
- > Demos
- > Training Materials
- > Enhancements

Stay Informed | Legal | Fraud and Abuse | Quick Links | TennCare Dr. Wendy Long

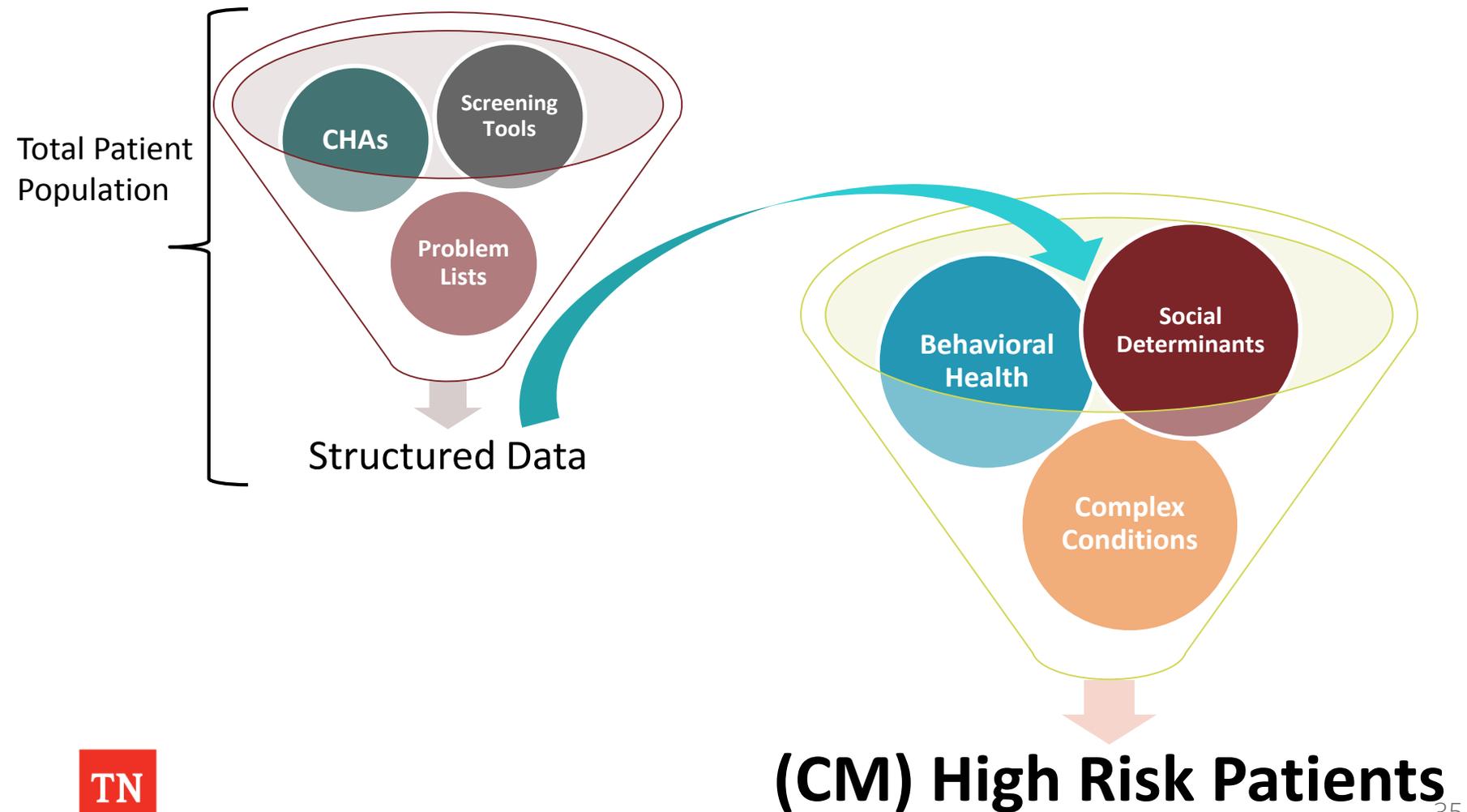
Waiver and State Plan Public Notices (updated on 12/1/17) | Estate Recovery | Program Integrity | FY 2019 Recommended Budget | 310 Great Circle Rd. Nashville, TN 37243 | 1-800-342-3145 | TennCare@tn.gov

12:30 PM 12/6/2017

- <https://www.tn.gov/tenncare/article/care-coordination-tool>



Identifying High Risk Patients (CM)



Your Practice's Population is Unique



Not as simple as...

- Demographics
- Insurance
- Diagnoses

What about...

- Local culture
- Local industry
- Access to healthy food
- Transportation
- Environmental exposure
- Community resources
- Social determinants

Identifying High Risk Patients (CM)

CM1 (Core): Considers the following in establishing a systematic process and criteria for identifying **patients who may benefit from care management**

(Must include at least three):

- A. Behavioral health conditions
- B. High cost/high utilization
- C. Poorly controlled or complex conditions
- D. Social determinants of health:
 - Also KM7 (2) Understands Social Determinants of health for patients, monitors at the populations level and implements care interventions based on these data
- E. Referrals by outside organizations (*e.g., insurers, health system, ACO*), practice staff or patient/family/caregiver

Patients Identified as High Risk

CM2 (Core): Monitor the percentage of the total patient population identified through its process and criteria.

- Using the criteria chosen from **CM01**, try to capture 5-15% of your total population
- That could translate to ~1-3 pts per Provider per day
- Identify patients that will benefit the **most** from self-management support
- Create identifiers that are trackable in your EMR

Documenting Your High-Risk Patient Visits

Time	Check In	Labs	Risk	Age / ...	Comments
08:00 ...		No	Yes	52y / ...	Follow up 15 - ...
08:00 ...		Yes	Yes	50y / ...	Follow up 15 - ...
08:00 ...		Yes	Yes	58y / ...	Lab 15 - Fastin...
08:15 ...		No	Yes	28y / ...	New Patient 30 ...
08:15 ...		No	Yes	32y / ...	Follow up 30 - ...
08:15 ...		Yes	Yes	78y / ...	Lab 15 - lab
08:15 ...		Yes	Yes	52y / ...	Follow up 15 - ...
08:30 ...		Yes	Yes	26y / ...	Follow up 15 - ...
08:30 ...		Yes	Yes	59y / ...	Lab 15 - Labs
08:45 ...		Yes	Yes	52y / ...	Lab 15 - fasting...
09:00 ...		Yes	Yes	64y / ...	Lab 15 - Labs
09:00 ...		Yes	Yes	41y / ...	Physical Exam ...
09:00 ...		Yes	Yes	40y / ...	Physical Exam ...
09:15 ...		Yes	Yes	38y / ...	Lab 15 - lab
09:15 ...		Yes	Yes	66y / ...	Follow up 15 - ...
09:30 ...		No	Yes	66y / ...	New Patient 30 ...
09:30 ...		Yes	Yes	28y / ...	Physical Exam ...
09:30 ...		Yes	Yes	61y / ...	Follow up 15 - ...
09:45 ...		Yes	Yes	31y / ...	Follow up 15 - ...
10:00 ...		No	Yes	34y / ...	Follow up 30 - ...
10:00 ...		No	Yes	24y / ...	Follow up 15 - ...
10:00 ...		Yes	Yes	66y / ...	Lab 15 - lab
10:00 ...		No	Yes	22y / ...	Follow up 15 - ...
10:15 ...		No	Yes	26y / ...	Physical Exam ...
10:30 ...		Yes	Yes	29y / ...	Office Visit 30 - ...
11:00 ...		Yes	Yes	51y / ...	Follow up 30 - ...
11:30 ...		Yes	Yes	64y / ...	Office Visit 15 - ...
12:00 ...		Yes	Yes	38y / ...	New Patient 30 ...
01:30 ...		Yes	Yes	21y / ...	Follow up 30 - ...
02:15 ...		Yes	Yes	52y / ...	Physical Exam ...
02:45 ...		Yes	Yes	36y / ...	Physical Exam ...
03:00 ...		Yes	Yes	61y / ...	Follow up 15 - ...
03:15 ...		Yes	Yes	50y / ...	Office Visit 30 - ...
03:45 ...		No	Yes	32y / ...	New Patient 30 ...
03:45 ...		Yes	Yes	35y / ...	Follow up 30 - f...
04:00 ...		Yes	Yes	29y / ...	Follow up 15 - ...
04:15 ...		Yes	Yes	34y / ...	Office Visit 15 - ...

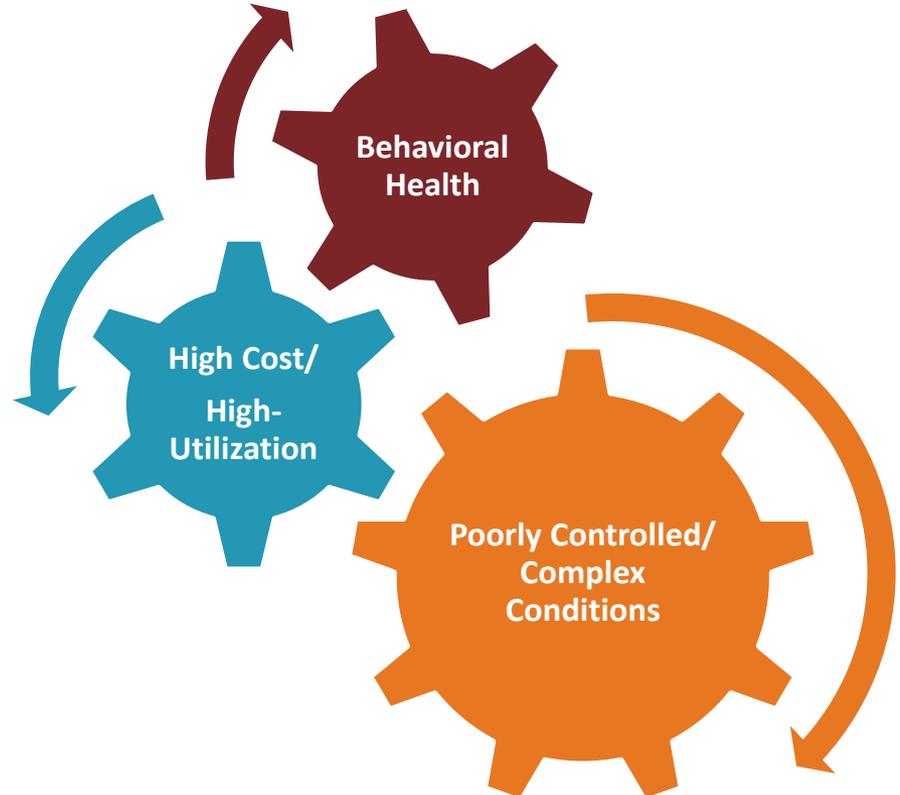
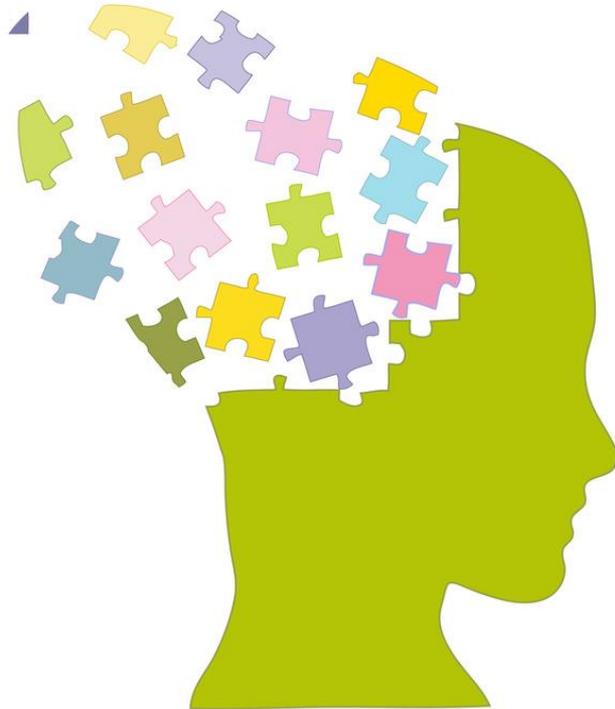
Flag them in your EHR

- This process will vary depending on the capacity of your EHR
- It is critical to your workflow

There are 3 High Risk Patients on this schedule

* Screenshot: from Allscripts

Brainstorming



What now?

- **Commonly Used Risk Stratification Models:**
 - **Hierarchical Condition Categories.** Implemented in 2004 by the Centers for Medicare & Medicaid Services for its Medicare Advantage plans
 - **Adjusted Clinical Groups.** Developed at The Johns Hopkins University to predict morbidity, the ACG model projects the use of medical resources in inpatient and outpatient services over a specific period of time
 - **Chronic Comorbidity Counts.** Based on publicly available information from the Agency for Healthcare Research and Quality's Clinical Classification Software, the CCC model groups patients into six categories based on risk as measured by the total sum of selected comorbid conditions
 - **Elder Risk Assessment.** The ERA model is used to identify patients 60 years or older who are at risk for hospitalization and ED visits.
 - **Charlson Comorbidity Measure.** Based on administrative data, the CCM model uses the presence or absence of 17 specific conditions to predict the risk of one-year mortality for patients with a range of comorbid illnesses.
 - **Minnesota Tiering.** The MT model groups patients into one of five complexity tiers based on their number of major conditions.

What now? Cont.

- **Applying/using the information**
 - Identifying a patient's health risk category is the first step toward planning, developing, and implementing a personalized care plan by the care team, in collaboration with the patient
 - Designing workflows in which patients are directed to different clinician types depending on that patient's risk -- ensuring all staff are operating at top of license
 - Systematically allocating more health coach/support staff resources to different panels
 - Making "Move patients at highest risk bands into lower risk bands over time" the operational goal of clinical protocols--lining up PCMH activities with the priorities of other stakeholders
 - Risk-Stratifying and Contracting/Incentives
- **Succeed with Value-Based Care**
 - Triple Aim - Improving the health of populations, reducing costs, and delivering a quality patient experience

Some Examples

Behavioral Health

- Dementia
- Anti-psych Meds
- Depression with Anxiety

~ADHD
~ Chronic Pain (Narcotics)

High Cost/ High Utilizing

- 8+ Medications
- 2+ IP visits in the last year

~NICU babies (Prematurity)
~Back Pain and 4+ visits in 6 mths

Complex/ Uncontrolled Conditions

- Diabetes with a second DM-related condition
- CYSHCN

Social Determinants of Health

- 70+ and living alone
- Foster Care/DSS Involvement

~Lives in housing project
~Unemployed

Referrals by an Outside source

- Insurer/ACO/CCWNC Priority List
- Provider selection

Remember Floyd?

What Standard Data Tells Us (KM)	
40 years old	
Hypertension	
Hypercholesterolemia	
CAD, Recent MI & CABG	
Often misses follow-up & routine appts	

Remember Floyd?

What Standard Data Tells Us (KM)	Digging Deeper... (CM)
40 years old	Frequent changes in insurance status due to chronic underemployment
Hypertension	Often lacks transportation
Hypercholesterolemia	Lives alone, no family nearby
Recent MI & CABG	Poor health literacy, difficulty managing medication regimen
Often misses follow-up & routine appts	Never followed up with Cardiac Rehab due to concern for cost of services

Stay Tuned...

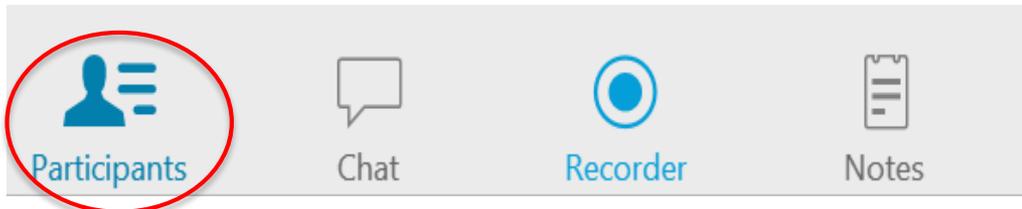
- **Continue Risk Assessment**
- **Allocating Resources Appropriately**
 - Tailor the development and distribution of patient materials
 - Coordinate with community partners
- **Implement Care Interventions**
 - Care Planning
 - Goal-Setting
 - Medication Management

Webinar Discussion

- BEST PRACTICES
- CHALLENGES
- NOVEL IDEAS
- QUESTIONS

HOUSEKEEPING

- The host will read comments from the chat box
- Please raise your hand to engage in discussion – we will unmute you when we call your name.
- Please lower your hand when you are finished speaking



Did you come up with a caption?



TN

Hey Kris, will you hold my spot?
Where are the cookies?

Next Session

Population Health Management: Risk Stratification Part 2

January 2018