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

Collect data about your population → Identify population needs → Apply resources to meet those needs
Population Health
Population Health

- Advanced Illness
- High Risk
- Stable
- Healthy / Low-risk

Total Patient Population
Assessing Population Health

Mike: 27yo, family hx of DMII, HTN. Healthy weight, gets regular exercise. Keeps routine and preventive health appts.
Assessing Population Health

Assessing Population Health

**Floyd:** 40yo, Obesity, HTN, Hyperlipidemia, CAD, recent MI & CABG. Often misses follow-up & routine appts. Poor adherence to medications.
Assessing Population Health

Elaine: 74yo, COPD, Stage 4 CKD, Debility. Home Health Services in place
Assessing Population Health

Elaine: Advanced Illness

Floyd: High Risk

Susan: Stable

Mike: Healthy / Low-Risk
Finding Opportunity to Make an Impact

Support Health Promotion & Prevention Planning

Susan (Stable)

Mike (Healthy)
Finding Opportunity to Make an Impact

Elaine
(Advanced Illness)

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

Total Patient Population

- Healthy / Low-risk
- Stable
- High Risk
- Advanced Illness
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)

Assessing the Total Patient Population

(CHAs) Structured Data

Screening Tools

Problem Lists

(KM): Structured Data
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

[Image of the CCT Screenshot]

### My Members

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<tr>
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<th>Save</th>
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**Risk Chart**

No Risk Level - 418 - 78.42 %
CCT continued

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<td>Additional Medical Health Info:</td>
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<td>Height:</td>
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<td>Not Available</td>
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</table>

- **Allergies & Sensitivities**
- **Vaccination details**
- **Preventive screening details**
CCT Information

https://www.tn.gov/tenncare/article/care-coordination-tool
Identifying High Risk Patients (CM)

Structured Data

Total Patient Population

CHAs
Screening Tools
Problem Lists

Behavioral Health
Social Determinants
Complex Conditions

(CM) High Risk Patients
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

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

Behavioral Health

High Cost/
High-
Utilization

Poorly Controlled/
Complex
Conditions
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

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **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  
~Lives in housing project  
~Unemployed |
| **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 |

---

**Questions:**

- Best Practice?
- Challenges?
- Novel Ideas?
- Questions?
## Remember Floyd?

<table>
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<tr>
<th>What Standard Data Tells Us (KM)</th>
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</thead>
<tbody>
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<td>40 years old</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Hypercholesterolemia</td>
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<tr>
<td>CAD, Recent MI &amp; CABG</td>
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<tr>
<td>Often misses follow-up &amp; routine appts</td>
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<tr>
<td>What Standard Data Tells Us (KM)</td>
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<td>Recent MI &amp; CABG</td>
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<tr>
<td>Often misses follow-up &amp; routine appts</td>
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</table>
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?

Hey Kris, will you hold my spot?
Where are the cookies?
Population Health Management:
Risk Stratification Part 2
January 2018