HW HealthTeamWorks Workforce_Development

2 Identifying Candidates for Care Management

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Introduction & Learning Objectives

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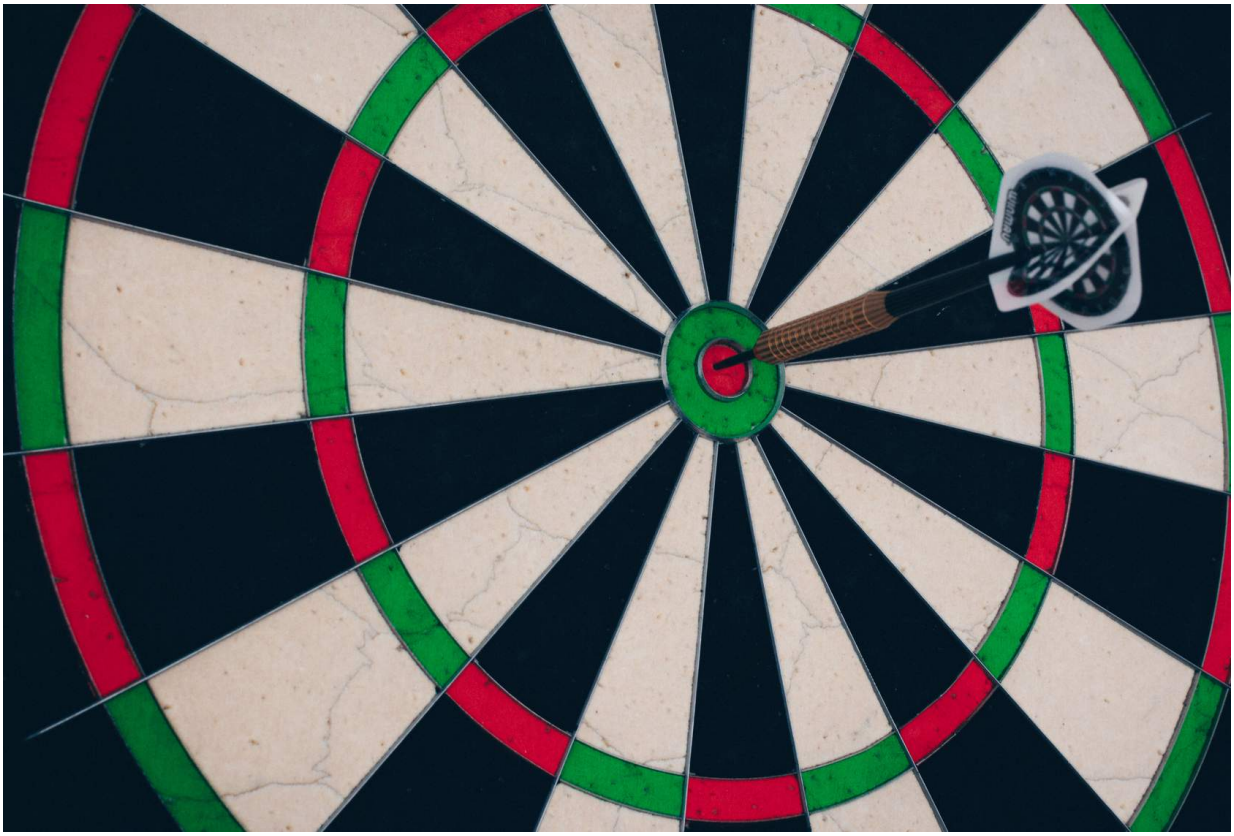
Now that we've defined care management, we need to identify who might benefit from care management services and support. In order to do this, we must fully understand our patient population, including their current resources or the existing provider and care team, and their health status. In this course, we'll cover empanelment and risk- stratification as a means to compile this information and identify potential candidates for care management.



Learning Objectives

Following the completion of this course, the learner should be able to:

- Describe empanelment and risk-stratification as a means to gain visibility to the needs of the active patient population.
- Clearly communicate the value of empanelment and risk-stratification in the context of care management.
- Compare different methodologies of risk-stratification to determine which methodology best fits your practice's needs and abilities.
- Apply the results of empanelment and risk-stratification to identify patients who could benefit from care management services.

What is Empanelment?

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What is Empanelment?

Empanelment is the process of assigning active patients to the primary care provider (PCP) and/or the care team. The PCP and the care team take responsibility for the COMPREHENSIVE management of that panel of patients. This includes:

- Preventive care needs such as physicals, immunizations, well woman exams, and screenings for conditions like breast cancer and colorectal cancer;
- Acute care needs such as the flu, Bronchitis, Pneumonia, and urgent symptoms that require evaluation and management (e.g. cholecystitis - referral to a surgeon); and
- Chronic care needs such as diabetes, COPD, heart failure, etc.

It is critical to note that through the management of all preventive, acute, and chronic care needs, the care is coordinated and comprehensive. It may include referrals, coordination of lab data with specialists, care planning, and care management, etc.

What Do We Mean by "Active" Patients?

An "active" patient is one that has been seen within a pre-determined "look-back" period. The "look-back" period is determined by each practice, based on their unique population. That said, most practices choose a look-back period of anywhere from 18-36 months. Meaning, if a patient has seen a provider within the specified look-back period, they are considered active. This allows the practice to capture those patients whose visits are primarily focused on preventive care and screenings. These individuals may see their physician only once per year so a 12-month look back may not capture those visits.

- [ ] If they have NOT been seen within the specified "look-back" period, they are considered INACTIVE.
- [ ] Once a patient is deemed inactive, the practice should have a process for either re-engaging the patient or removing that patient from the provider/care team panel.

If the practice sees patients for one-off acute visits, patients that do not necessarily consider the practice their primary care home, these patients will need to be excluded from the "active" patient panel. This is a common issue for practices that reside in vacation destination geographical areas. For example, practices in Florida or Colorado (ski season) will need to pay particular attention to the patient list as they are assessing for active patients.

Maintaining Empanelment

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Empanelment is not a one-time event. Rather, it is an ongoing, iterative process, through continuing to assign new patients and re-activated patients and the periodic re-evaluation of the assigned panel on a pre-determined regular basis.

Many practices utilize reports to review the empaneled population on a quarterly basis but some may review as frequently as monthly or as infrequently as annually.

What is important is that the practice defines a process, allocates resources to that process, and holds everyone accountable to their part in maintaining the panels.

Important elements of the process include:

- A method for assigning new patients and re-activated patients
- A defined periodic schedule for review of existing panels
- A designated individual, or Panel Manager, assigned to conduct the empanelment process
- How to review panels with each provider

A sub-process that may be added to the overall goal of empanelment is clearing or re-activating patients. This will require additional resources to conduct an outreach campaign so consider your current capacity and the volume of inactive patients that could potentially become active.

For more information on managing provider panels, see “Empanelment: Managing Provider Panels” in the Solutions Center Resource Library.

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The Value of Empanelment

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Empanelment has many benefits that can be categorized in several ways:

The Benefit to the Patient

First and foremost, the patient benefits from receiving care from a consistent provider and team. The care team gets to know the patient, understand their preferences, their challenges, and learns how to best communicate with the patient in a way that they will be receptive and understand. Trust is built over time. This increases efficiency and improves follow up.

The Benefit to the Provider

With empanelment, patients are seen by their chosen PCP/care team the majority of the time. This can dramatically improve efficiency (e.g., less time spent conducting chart review on complex/unfamiliar patients) and increase satisfaction. The transparency of panel sizes, as well as to the acuity of the panel can help the practice modify the allocation of human resources to accommodate for larger and more complex panels or reassign patients to a different provider/care team if patients are willing.

The Benefit to the Care Team

Empanelment enables the development of effective care teams and workflows, which can also have the downstream effect of job satisfaction. Additionally, empanelment increases quality and can decrease hospital admissions, readmissions, and ED utilization.

Why does Empanelment Matter to a Care Manager?

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For all of us, no matter what role we work in, it's important to understand the "Why" behind doing something, and how that information relates to our role.

Let's look at Empanelment, and understand why empanelment matters to a Care Manager:

1. Which patients are active?

This is important because we need to know which patients are active in order to know who's eligible for care management services. If we try to provide care management services to a patient who isn't ACTIVE and CONNECTED with the practice, we will not be successful (we don't have enough current information)
Also, looking at the financial aspect of care management, we need to be mindful of how and where we deploy an expensive resource like a care manager.

2. Precursor to Risk Stratification

Risk stratification is the science and art of using information such as a patient's clinical diagnoses, utilization or claims data, physical status, social determinants of health, and care team anecdotal information to identify interventions to improve or maintain health status
Stratifying the population by risk identifies those patients who require additional time, attention, and/or resources and creates a common language for the practice to allocate resources accordingly.

3. Visibility to entire practice population

Because a Care Manager is in a somewhat unique position to have a broad knowledge and visibility of the entire practice, empanelment will provide an overview of practice happenings including the size of provider panels. When risk stratification is deployed, it will also inform the Care Manager about the complexity of each provider's panel

What is Risk Stratification?

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Risk stratification is the process of grouping patients into tiered categories of risk based upon the level of complexity of each patient's health status.

Like empanelment, risk stratification is NOT a one-time event. Rather, it is a dynamic and ongoing process. As individuals age, health status changes, and social support or social needs change, the risk level can change too. This is why it's important for practices to have a process that is dynamic and ongoing.

Most stratification models are used to predict any one or several things:

- The likelihood of adverse health events and/or poor outcomes
- The likelihood that the patient will need care management support
- Some stratification models predict RISK for ED visits within a specified period of time
- Other models are designed to predict mortality
- All models can predict the likelihood of the need for primary care and other services

Ultimately, the purpose of a risk stratification tool is to help the practice categorize patients into groups that determine how much support and services the patient will need. Risk stratification also helps the team know which patients are most likely to benefit from care management support.

Now let's take a look at how a risk stratification model is deployed, and what pieces of data are captured within an algorithm!

How Risk Stratification Algorithms Work

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Ideally, risk stratification should be automated within the EHR or an add on software that is linked to the EHR. For many EHRs, deploying the risk stratification functionality is an additional cost. And, because of this, some practices do not purchase this portion of the software.

Add-on software might be less costly, but there are inherent challenges with using this method. The most common challenge is interoperability of the add-on software with the existing EHR. Sometimes the cost of establishing data feeds between the EHR and risk stratification add-on ends up being just as costly as it is to purchase the EHR risk stratification module.

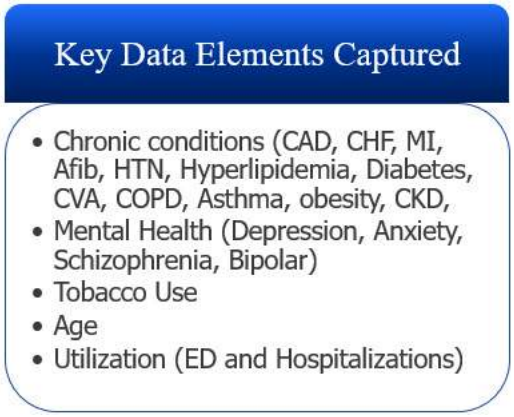
For practices that do not have the financial means to purchase a risk stratification tool, a manual process can be implemented. While this is extremely time-consuming and less than ideal, it is still better than not stratifying the population at all.

In this circumstance, the practice will need to select an algorithm and establish a process to apply the algorithm to the entire population, and document risk scores/levels in the EHR. Additionally, it is important to establish a process and frequency to revisit the risk score/tier of each patient and reassign a new score if it has changed.

While each risk stratification algorithm is unique, most algorithms assess similar aspects of clinical and social data to categorize the patients.

Chronic conditions are a key aspect of any risk stratification algorithm. Most algorithms will look for certain chronic conditions (CAD, COPD, MI, CHF, asthma, diabetes, CKD, HTN, etc). Most algorithms will also account for the number of chronic conditions and, the more chronic

conditions a person has, the higher the score.



Other data elements that might be captured, depending on the algorithm include:

- Certain mental/behavioral health conditions
- Tobacco use
- Age of the patient (with higher age accounting for more points in the algorithm)
- Utilization pattern of the healthcare system (specifically ED and hospitalization)

The risk stratification software analyzes the data of each patient (based on the algorithm) and assigns each patient to a risk tier. Just as there are many different algorithms, there are also several different ways that the models approach "grouping" the patients:

- The most basic models only use two tiers of risk, e.g., No risk, At-risk, these models are less common and also less effective for the practice in determining how to deploy additional services for patients that may benefit
- Some modules use three tiers of risk: Low, Medium, and High
- Other models separate patients into multiple categories with the top tier including only the most serious and complex patients that are at end of life.

3 Tier Risk Stratification

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This is an example of a 3 tier risk stratification model:

In a 3 tier model, the practice panel is sorted into 3 different tiers of risk:

1. Low Risk: The low-risk patients are those that are generally healthy and typically only require preventive care and/or an occasional urgent visit.
2. Medium Risk: The moderate risk patients are those that may have one or more conditions that require management but are generally stable.

3 High Risk: The high-risk patients are those that are medically complex, even fragile, with any combination of multiple conditions, polypharmacy, complex social needs, poor self-management, frequent exacerbation, and even end of life needs.

For a 3 tier model deployed in a practice with an average payer mix, the low-risk group typically comprises approximately 60-75% of the population; the medium risk comprises anywhere from 25-35% of the population, and the high risk comprises anywhere from 5-15% of the population.

In this model, the Care Manager will focus on High-Risk patients, those at the top portion of the pyramid. It’s important to know that not all patients in this category are likely to benefit from care management services, and not all patients that are eligible for care management will be amenable to receiving the service. For example, a patient categorized as "High Risk", who is at end of life, already enrolled in hospice care and has excellent family support is unlikely to benefit from care management services based in primary care.

Next, let's look at a more complex risk stratification model.

5 Tier Risk Stratification

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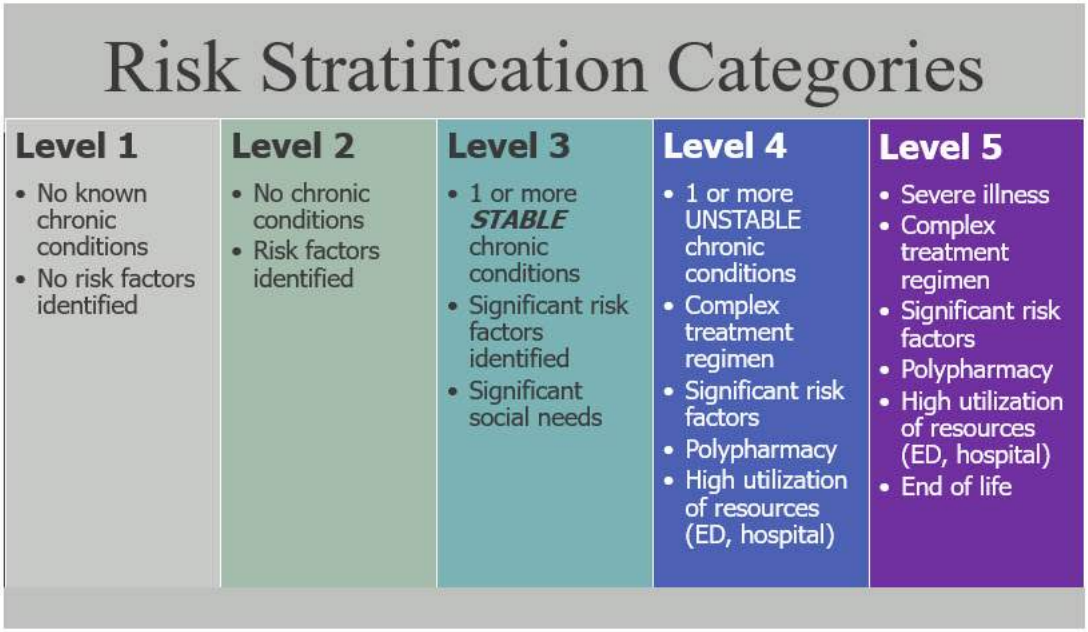
Here, we have a five-tiered risk stratification model. It groups patients into five "levels".



- **Levels 1 & 2** - includes patients that are generally healthy. Those in level 2 may have some risk factors (like tobacco use, overweight, or family history).

- **Level 3** - includes patients that may have one or more chronic conditions, but the condition(s) is stable and well managed with medications and/or lifestyle. These patients may have some significant risk factors and/or social needs.

  Depending on the risk factors and social needs, these patients are likely to benefit from intervention tailored to their unique needs. For example, a patient in this category who is overweight with a family history of diabetes, is dependent on food stamps and has limited financial resources may benefit from a nutritional consult with a dietitian, and referral to social work to determine if there are any resources available to reduce the financial burden.

- **Level 4** - where we begin to see patients that may benefit from targeted care management services. These patients have one or more chronic conditions that are unstable, meaning they are having periodic (or even frequent) exacerbations that require ED/hospitalization or frequent visits to PCP. These patients, if amenable, will typically benefit from targeted education, SMS, and personalized care planning.

- **Level 5** - houses the most complex patients. This group typically comprises a very small portion of the practice population. These are patients experiencing catastrophic illness and/or are at the end of life. Care management services may benefit this group of patients. Care Managers should assess patients in this category, obtain input from the care team, and deploy services as indicated. Some patients in this group may need long term complex care management support, whereas others will not need or benefit from the service. A comprehensive review is needed to make this determination.

2 Step Risk Stratification Process

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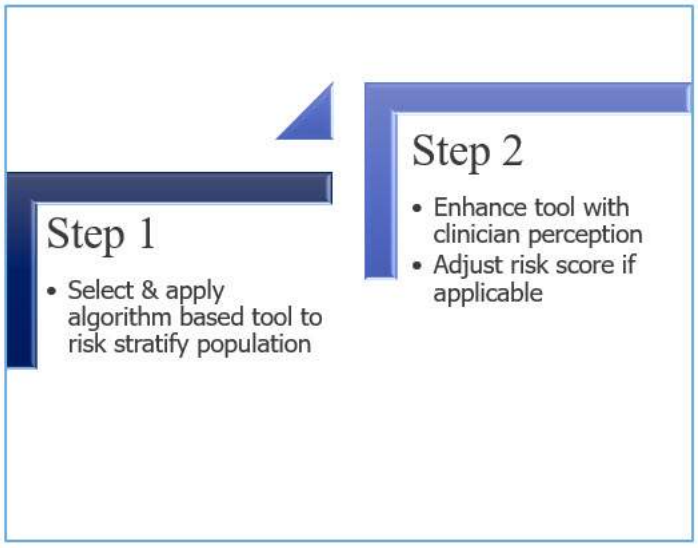
Now, let's take a look at another aspect of risk stratification that's important:

The addition of clinician judgment!

No matter how comprehensive or effective a risk stratification algorithm is, it cannot replace clinician judgment. In fact, approximately 20% of patients are inaccurately categorized by an algorithm. A clinician will understand subtle nuances about a patient, or have knowledge of certain socio-demographic factors that impact a patient's ability to self-manage. Factors which cannot be captured in even the most sophisticated risk stratification algorithm.

Practices that successfully use this "second step" for risk stratification have several things in common:

1. All care team members can weigh in with what they know about the patient (not just physicians or Care Managers. This includes MAs and front office staff, who often know social factors about a patient that no one else knows)
2. There is a standardized process for incorporating this step into the model (e.g. completed at the time of office visit, specifically during a well-visit, or chronic condition visit for those with chronic issues)
3. The EHR has technology that allows the risk score to be manually adjusted


Step 1
• Select & apply algorithm based tool to risk stratify population
Step 2
• Enhance tool with clinician perception
• Adjust risk score if applicable

Lesson 11 of 13

Why Does Risk Stratification Matter?

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Why does risk stratification matter to a care manager? Why is it important to have this foundational knowledge?

By employing a risk stratification method, both the patient and the practice will benefit.

The patients benefit because they will finally receive proactive care that addresses their specific level of need. Their care becomes more relevant and applicable.

The care manager is more easily able to identify patients with chronic conditions that may benefit from longitudinal care management.

Overall, risk stratification allows the provider and the care team to more efficiently allocate resources to match the needs of their patients resulting in better patient experience, improved health outcomes, lower cost of care, and improved provider and care team satisfaction.

Test Your Knowledge

Question

01/05

What is Empanelment?

- The act of bringing a group of patients with the same conditions together in one room.
- The process of assigning risk levels to patients based on factors such as health status, social needs, and utilization of hospital and emergency department services.
- The science of using patient information to identify the interventions to improve or maintain health status based on tiers.
- The process of assigning active patients to a PCP and/or a care team.

Question

02/05

Which of the following demonstrates the value of empaneling patients into care management? (Choose all that apply)

- [ ] The practice makes more money.
- [ ] There is little to no added value in empaneling patients.
- [ ] Increased efficiency due to the fact that patients with the highest need will be taken care of.
- [ ] The patients with the most complex needs will have the opportunity for specialized care.

Question

03/05

Risk stratification is NOT ...

- Categorizing patients based on how well or quickly they or their insurance provider pay the practice.
- The process of grouping patients into tiered categories based on their level of complexity.
- The art and science of using patient information to identify interventions to improve or maintain health status.
- The process of separating patient populations into high-risk, low-risk, and the ever-important rising-risk groups.

Question

04/05

There is only one proper way to risk stratify.

- True
- False

Question

05/05

From the list below, who benefits from empaneled and risk-stratified care management?

- [ ] The Patient
- [ ] The Community
- [ ] The Care Team

Activity Instructions

Practical application of what you are learning helps with skill development and retention. We have created an activity that will guide you in that type of application.

- [ ] Visit https://www.healthteamworks.org/resource/essentials-care-management-activities-and-resources.
- [ ] Find and download the activity assigned for this course.
- [ ] Complete the activity. You are encouraged to work with your team to complete the activity.
- [ ] Email the completed activity to caremanagement_nachc@healthteamworks.org.
- [ ] Make sure to add the Course Activity Title you are submitting and your full name to the Subject Line of your email.
- [ ] You will receive feedback on your completed assignments.