Getting Started with Risk-Stratified Care Management

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Harry Takaji Kittaka, Jr., MD

Chief Medical Officer and Chief Transformation Officer, Adena Health System, Chillicothe, Ohio; Physician, Adena Family Medicine, Waverly, Ohio; Medical Director, Adena Healthcare Collaborative (ACO), Chillicothe, Ohio.

Dr. Kittaka graduated from the University of Nevada School of Medicine, Las Vegas, and he developed a love for population health during his family medicine residency with Intermountain Healthcare at the Utah Valley Family Medicine Residency, Provo. He practices in rural Appalachian Ohio, where one of his greatest passions has been serving as team physician for the Waverly High School Tigers for the past 16 seasons. In his positions with Adena Health System, Dr. Kittaka uses his Six Sigma Black Belt training and love of analytics to seek solutions for population health. He and his teams have developed pathways and guidelines that address socioeconomic challenges in rural Appalachia and use risk stratification to allocate valuable resources. His projects have involved acute care, post-acute care settings, and outpatient family medicine clinics.

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Gary L. Bevill, MD, FAAFP

Founding partner and physician, SAMA Healthcare Services, El Dorado, Arkansas; Medical Director, Hudson Memorial Nursing Home, El Dorado, Arkansas.

Dr. Bevill is board certified by the American Board of Family Medicine (ABFM) with a Certificate of Added Qualifications in geriatric medicine. He lives in El Dorado, a town of 18,000 located in south central Arkansas. He practices at SAMA Healthcare Services, which serves more than 30,000 patients. SAMA has been using an electronic health record (EHR) system since 2002. In 2012, the practice was chosen as a Comprehensive Primary Care Initiative (CPCi) clinic and started the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition program. SAMA's team-based patient care model-which involves heavy use of information technology (IT)-has been recognized by Arkansas Blue Cross and Blue Shield (BCBS), the Arkansas Department of Health, and the Arkansas Medical Society for its cutting-edge transformation of traditional patient care. SAMA has been recognized nationally as one of the best comprehensive primary care (CPC) clinics and has been covered by numerous media outlets, including a feature on MSNBC's web edition. Dr. Bevill believes the biggest challenge in the future of family medicine is managing EHRs, IT regulatory burdens, and the explosion of data without losing the patient in the process. He is passionate about using technology to achieve the best care management and population health possible.

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Jamie Osborn, MD

Physician, Safeway Healthpointe Center, Pleasanton, California.

Dr. Osborn is a disruptive innovator. After spending 17 years as a family medicine educator, she now focuses her efforts on healing health care delivery through innovative transformation. She served for 10 years as director of the Loma Linda University Family Medicine Residency Program, California, where she established a rural track, a combined family medicine-preventive medicine residency, and a teaching health center. She now enjoys practicing full time as a clinician in an Accreditation Association for Ambulatory Health Care (AAAHC)-accredited patient-centered medical home (PCMH), where she finds the teamwork especially gratifying. Safeway Healthpointe Center is operated by QuadMed, a company that delivers employer-sponsored direct primary care (DPC). Dr. Osborn enjoys having time and space to offer whole person care at a relaxed pace to her patients of all ages. She especially enjoys integrating behavioral, social, and spiritual care as healing arts. Although she misses delivering babies, she keeps her childlike wonder by finger painting, and reading and writing poetry.

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Learning Objectives

1. Explain the importance of risk-stratification and care management for patient care and value-based payment models.
2. Compare different implementation efforts in various practice settings.
3. Identify free resources to support the implementation of simple risk stratification for managing your panel of patients.
4. Strategize ways to implement risk-stratified care management in your practice.

Audience Engagement System

Step 1 Step 2 Step 3

Patient-Centered Risk-Stratified Care Management

(Happily on a Shoe-String Budget)

Jamie Osborn, MD

Context: Safeway Healthpointe Center

- Operated by QuadMed starting 2013
- Employer-sponsored PCMH for Safeway Corporate Employees in Pleasanton, California
- 9 person team: MD, FNP, RN, 4 LVN, Nutrition/CDE, insurance liaison
- Initially @4000 eligible patients; ~ 25% adoption rate by April 2014
- AAAHC PCMH certified in September 2014
- **DISCLAIMER: I DON'T TAKE MEDICARE AND I DON'T BILL INSURANCE**

How we got started: AAFP Free Resources!!!!

- Hand compiled (XL) Registry for all our diabetics: 2013
- Discovered AAFP's Risk Stratified Care Management rubric at Conference on Practice Improvement, Dec 2014
  - 6 Tiers of patient risk based on chronic disease and complications
  - Simple designation
  - Suggested population outreach strategies for each tier
- Wondered: Could we implement this?

Health Risk Levels

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Healthy	Risk Factors	Chronic Disease well controlled	Chronic disease not well controlled	Morbidity or complication from disease	End-stage, terminally ill, comfort care
Well thin person	Overweight pre-diabetic smoker	Obese Diabetic well controlled	Morbidly obese uncontrolled diabetic	Diabetic with renal, nerve, or vascular disease	ESDR on HD Stage 4 Cancer or CHF

https://nf.aafp.org/Shop/practice-transformation/risk-stratified-care-mgmt-rubric

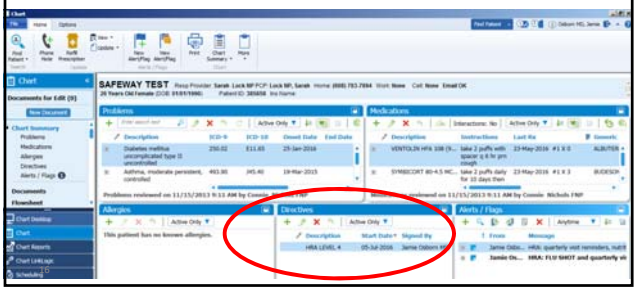
Jan 2015
Identify at risk patients: ASK THE TEAM

- Asked each team member to give me a list of the 10 patients they were most worried about
  - Compiled list of 15 patients; same 6 patients showed up on everyone's list
  - Had a team "care coordination" meeting on two families (6 of the patients)
- Team LOVED it. Everyone had something to contribute and we felt ownership of this family's health

Feb 2015
Identify At-risk Patients: Assign Risk Levels

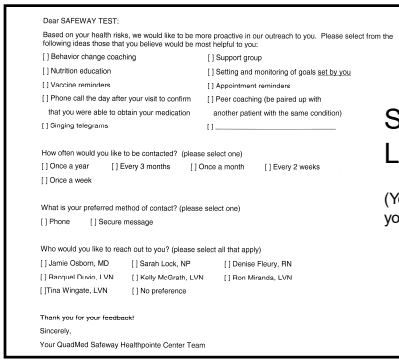
- Providers assigned Health Risk Assessment (HRA) level to each patient for next 6 months
  - Worked backwards to assign risk to patients seen in past 12 months
- Entered HRA status in **searchable field, easily visible** on patient summary page ("Advanced Directives")
  - Report generated monthly to catch any patients missed
- Identified 62 patients in the first month with HRA ≥ 3
- By April, 50 level 4-5 patients identified

Screen Shot: HRA Level



March 2015
Start Out-reach…But How?

- Brainstormed with the team again
  - Choose sickest patient? Simplest intervention? Most important issue Most common diagnosis?
- Decision: Let's **ASK THE PATIENTS**
- Designed HRA letter that asked patients
  - What type of outreach desired (appointment reminders, nutrition advice, vaccine reminders, singing telegrams for preventive services)
  - Who is preferred team member for outreach
  - What method of communication
  - What frequency of communication
- Used "Care Alerts/Flags" system to show patient preferences and send reminders



Dear SAFEWAY TEST:

Based on your health risks, we would like to be more proactive in our outreach to you. Please select from the following ideas those that you believe would be most helpful to you:

[ ] Behavior change coaching
[ ] Support group
[ ] Nutrition education
[ ] Setting and monitoring of goals set by you
[ ] Vaccine reminders
[ ] Appointment reminders
[ ] Phone call the day after your visit to confirm that you were able to obtain your medication
[ ] Peer coaching (be paired up with another patient with the same condition)
[ ] Singing telegrams
[ ] _____

How often would you like to be contacted? (please select one)

[ ] Once a year [ ] Every 3 months [ ] Once a month [ ] Every 2 weeks [ ] Once a week

What is your preferred method of contact? (please select one)

[ ] Phone [ ] Secure message

Who would you like to reach out to you? (please select all that apply)

[ ] Jamie Osborn, MD [ ] Sarah Lock, NP [ ] Denise Fleury, RN
[ ] Racquel Ocon, LVN [ ] Kelly McGrath, LVN [ ] Ron Miranda, LVN
[ ] Tina Wingate, LVN [ ] No preference

Thank you for your feedback!

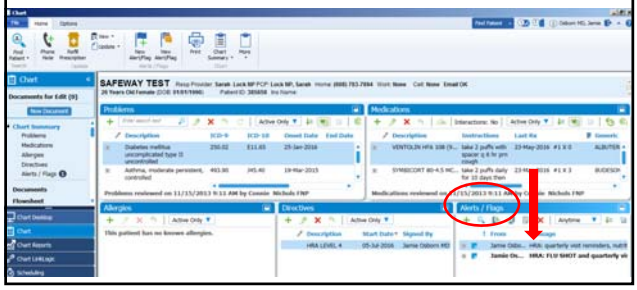
Sincerely,

Your QuadMed Safeway Healthpointe Center Team

Sample Patient Letter

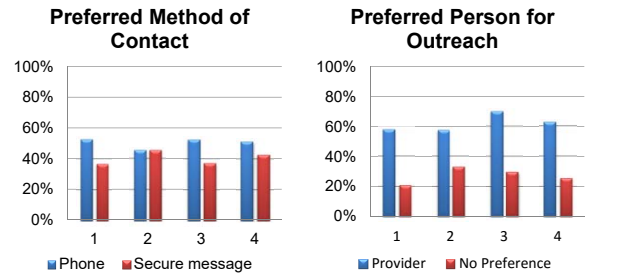
(Yes, feel free to steal whatever you like here.)

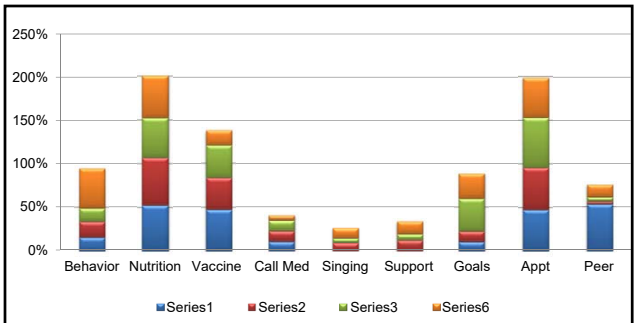
Screen Shot: HRA Plan



Making It Patient-Centered

- Recruited a patient (dependent retiree with DM, HRA level 4 -> 3)
- Joined our monthly meetings to help us refine the process and understand what it felt like to live with chronic disease
- He offered to be the peer coach for our DM patients as well.
  - Although several patients indicated interest, none contacted him.





Lessons and Surprises

- Lovely discussion process of how to stratify obesity or mood disorders
- We had more level 4 patients than we thought we would have
- Our problem lists were chaotic and needed prioritization
- Be more specific when asking what patients want
  - Does “appointment reminder” mean a phone call the day prior to apt or a notification when it is time to return for a routine follow up or that we have to take responsibility to make all the follow-ups for acute things?
- Patients usually chose to be contacted at the interval that we would have chosen for them!

Is This Sustainable?

- Goal: 80% of patients HRA level 4 or higher will adhere to planned visit/outreach.
  - 58% charts fully compliant with plan (July 2016)
    - Most deficiencies were HRA letters not returned
  - 72% contact documented even if no plan charted
    - (i.e. DM seen in last 3 months even though patient had no letter returned)
  - Takes monthly to quarterly review to keep up

Future Directions

- Need better ways to track patient goals and vaccines
- Registry was purchased (ENLI CareManager). (It is a start)
- Staffing cut to 3 (me and two LVN's) due to client's "merger"
- Used registry to outreach for flu vaccines and some preventive tests (Pap smears) with modest responses

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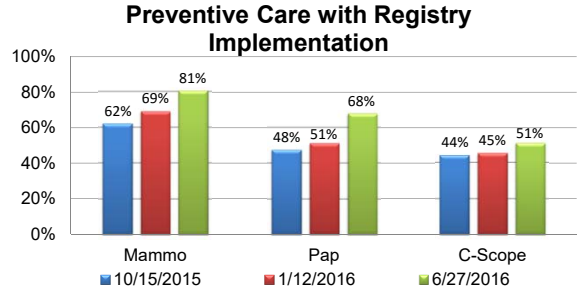

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Practice Recommendations

- AAFP resources are free and very user-friendly
- Patient-centered Population Management can be done on a low budget with moderate time commitment
  - 3-4 hours team meeting and initial training
  - 30-45 sec/pt to update problem list
  - 15-30 sec/pt to assign HRA levels
  - 2 min/pt clerical entry for staff to document patient communication and requests
  - 5-10 minutes to respond to alerts daily
  - Half day per 100 ill pts/qtr to provide QA and ongoing monitoring; less for lower risk

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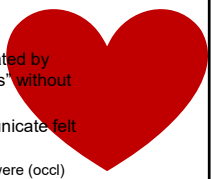
Practice Recommendations

- It is all about the LOVE
  - Real transformational change is ONLY mediated by love, not by fear (nagging, threats, "reminders" without real relationship)
  - Methods only work inasmuch as they communicate felt connection and love
    - People without a personal relationship with me were (occl) put off by letters or reminders
    - Doesn't matter what I say or what I do, if I don't do it for love, it's worthless. (Paul, 1 Corinthians 13)



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Contact Information

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SAMA HEALTHCARE

Practice Transformation within the Comprehensive Primary Care Initiative (CPC) with Emphasis on Care Coordination and Risk Stratification

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Gary Bevill, MD, FAAFP

- Bearden Arkansas
- OBU
- UAMS
- Founding Partner 1999
- ABFM, CAQ Geriatrics

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SAMA Healthcare Services

- El Dorado, Arkansas
- 20,000+ active patients
- EMR
  - Allscripts Professional EHR
- Open extended hours and weekends
- Same day appointments available
- Full Service: Lab, X-Ray, CT, US, Bone Density, Allergy Clinic, and Pharmacy on Site

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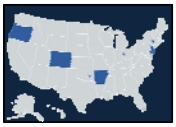
Comprehensive Primary Care Initiative



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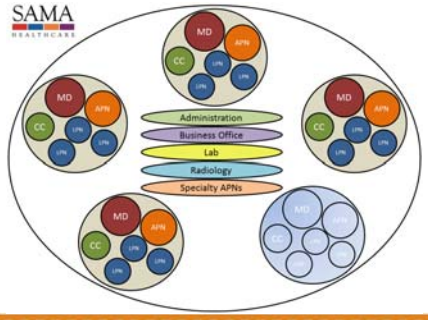

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Change

- 2008-2012
  - 27-29 Employees
  - Four MDs and Two APRNs
- August 1st 2013
  - 37 Employees
  - Four MDs and Two APRNs
- Today
  - 63 Employees
  - Six MDs and Six APRNs
  - One Licensed Clinical Psychologist

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True / False ?

Participation in CPCI for SAMA Healthcare led to team formation and radical transformation of patient care.

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Care Coordinators

- Risk Stratification Management
- Transitions of Care / Referral Management
- Gaps in Care

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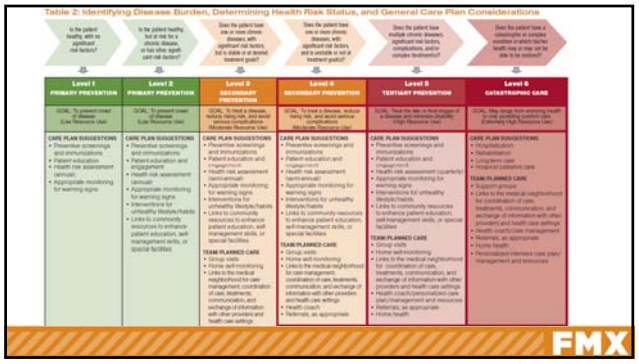

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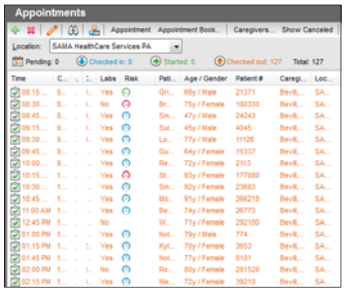

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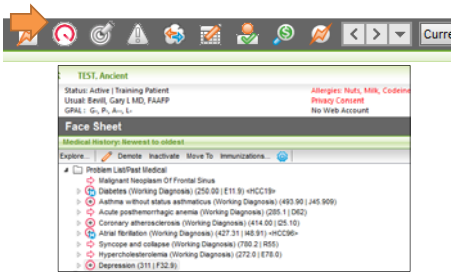

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Yes/ No?

Was Risk Stratification a dramatic change for SAMA Healthcare?

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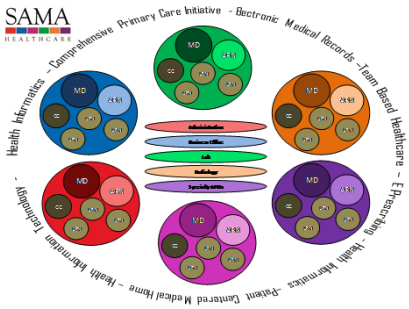

Practice Recommendations

- SAMA believes that Risk Stratification improves patient care and outcomes.
- Team based care with care coordination benefits the patient.
- Patient centered care … It's all about the patient!

SAMA
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Chief Transformation Officer
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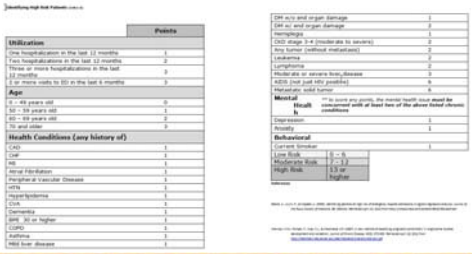
ADENA Health System

Adena Profile

Founded:	June 1895
Location:	Chillicothe, OH (45 min. south of Columbus)
Service Area:	12 counties in south central Ohio
	520,877 (U.S. Census – 2015 estimates)
Staff:	3,038 Total Employees
	233 Employed Providers (156 physicians & 77 mid-levels)
	33 Physician Residents
Hospitals:	Adena Regional Medical Center (Chillicothe, OH)
	Adena Pike Medical Center (Waverly, OH)
	Adena Greenfield Medical Center (Greenfield, OH)

Regional Health Centers: Circleville; Chillicothe; Greenfield; Hillsboro; Jackson; Oak Hill; Piketon; Washington Court House; Waverly; Wellston

Evolution



Diabetic Specific Stratification Added

Measure	Value	Points
HbA1C	<7	0
	>=7 and <=7.9	1
	>=8 and <=8.9	2
	>= 9 and <=9.9	3
	>= 10 and <=10.9	4
	>= 11 and <=11.9	5
	>= 12 and <=12.9	6
LDL	<100	0
	>=100 and <=130	1
	>130	2
BP	<130/80	0
	>130/80 and <=140-90	1
	>140/90	2
Diabetes Type	Type 2	0
	Type 1	1
BMI	<=24.9	0
	>=25 and <=29.9	1
	>30	2
Admission to hospital or ED visits	1	2
	>1	3

Low Risk =	0 – 2points
Moderate Risk =	3 – 5 points
High Risk =	6 – 16 points

Reference: The Advisory Board Company (2011, April 4). *Risk stratifying patients – Two example approaches*. Retrieved November 28, 2011 from http://www.advisory.com/Research/Health-Care-Advisory-Board/Blogs/The-Blueprint/2011/04/Risk-Stratifying-Patients-Two-Example-Approaches

Using Population Managers

Implementation Using Staff

9 Nurse Navigators

4 Population Managers

13 Practices / 33 Family Practice, Internal Medicine, Pediatrics / 20 Nurse Practitioners

Conception: Pilot & Partnership

ADENA HOSPITAL
A non-profit regional hospital recently formed an ACO and was looking for innovative ways to care for patients in the community

NATIONAL CHURCH RESIDENCES
A non-profit community health provider that developed a home assessment model that addresses the social determinants of healthcare

WHY PARTNER?

- To provide enhanced services for higher-risk patients
- To pilot a Population Health Management strategy
- To demonstrate a collaborative effort to promote better health outcomes and financial savings
- The planned outcome: Lower Costs and Better Care!

Pilot Kick Off…

ADENA

Using Medicare Claims data as part of their ACO program, identified **100 high risk COPD** patients who had utilized the system in FY 2015.

- Total cost of care for these 100 patients was $7.6 million in one year
- $62,344/avg annual spend per patient

National Church Residences

- Hired an Enhanced Service Coordinator
- Visited each patient in their home
- Assessed for needs/social determinants
- Connected patient to community services
- 1 X Month – IDT meeting with Adena Transition Coordinators

Execution of the Pilot

Adena PCMH Staff: *Patient Centered Medical Home navigators provide education, coaching, and long term monitoring of each patient*

Enhanced Service Coordinator *goes to each patients home, assesses need, connects patient to services impacting the social health determinants*

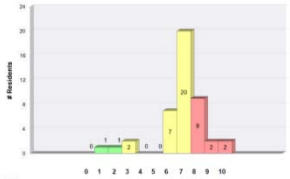
Adena Inpatient Staff *Hospital Social Workers meet monthly with the service coordinator and PCMH navigator to communicate proactively about the needs of hospitalized patients*

Physician *communicates with navigators to provide consistency of care*

Preliminary Findings

70% scoring a 7 or higher on VES Scale
74% is 65 or older
58% is dually eligible
80% has 3 or more chronic diseases

- 100% COPD
- 73% Diabetes
- 68% CHF
- 45% Cancer Diagnosis



Activities of Daily Living

- 74% need assistance with meal preparati…
- 67% need assistance with medication management
- 50% need assistance with bathing, ambulation, grooming, and dressing

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Success Story

PT: 70 year old female
Score of 7: VES

Living Environment: PT has a daughter and a granddaughter who live with her and assist her with most of her daily needs. Previously had an aide coming in once per week but was not satisfied as the Aide spent a lot of time on her phone. She also had meals on wheels.

Diagnosis: Renal disease = dialysis 3 days/ week
Chronic pain / weakness in her hands

CHF	Obesity	COPD
Diabetes	Hyperlipidemia	

2015 Medicare Expense: $95,342.88
14 ER visits
5 hospitalizations

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Success Story

Home for Life Assessment: April 10, 2016
Referrals made to:

SKILLED HOME HEALTH: Occupational Therapy, Physical Therapy & Nursing Med Management

MEDICAID WAIVER/AIDE PROGRAM: New Home Health Aide (requested a new company and a new aide to provide services since patient was unhappy with the previous aide.) Aide provides cleaning, cooking, and personal care services. Service Coordinator was able to increase the hours from 1 day per week to 3 days per week. Patient is very satisfied with the new person coming in.

ADULT DAY: Service Coordinator made referral to adult day services once per week in order to provide respite for patients daughter and granddaughter.

HEALTHCARE UTILIZATION SINCE HOME FOR LIFE ASSESSMENT:

0 Unplanned hospitalizations

1 Planned hospitalization for a blood transfusion that was scheduled by her dialysis.

Note: This past week her dialysis dropped her and she went to the ER but was not admitted. Service Coordinator is meeting with the Dialysis Center to prepare for a better plan of care than an ER admission.

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Key Takeaways

- What does this patient need/want?
- Teams and relationships are key
- Consider sustainability and profitability
  - Use free AAFP member resources, partner with community

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Practice transformation is not pearl diving, but becoming the pearl.

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Questions

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aafp.org/fmx-practice-management

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