Care Management

February 2, 2017

Dr. Asaf Bitton, Amy Gibson, and Jennifer Miller
1) Practice Introduction
2) Review Driver Diagram, Change Concepts & Requirements in Care Management
3) Longitudinal and Episodic Care Management
4) Risk Stratification
5) Additional Learning Support
6) What’s Coming Next in CPC+
7) Live Question and Answer (Q&A) Session
Northwest Primary Care

- Located in: Oregon
- Providers: 28 providers supporting five family and internal medicine clinics
- Patients: 28,500 active patients
- EHR: Intergy
- Risk stratification algorithm: AAFP Risk Stratified Care Coordination Tool

Daniel Wilkes, MSW
Northwest Primary Care
Sellwood/Westmoreland
Clinic Manager
Care Coordination Director
Function 2: Care Management

- Systematically **risk stratify** empanelled population to identify **high risk patients** likely to benefit from targeted, **proactive, relationship-based** (longitudinal) care management
- Identify patients based on **event triggers** for **episodic** (short-term) care management regardless of risk status
- Analyze internal monitoring and payer **data**
- Use **care plans** congruent with patient choices and values
Care Delivery Requirements: Care Management

Requirements for Track 1

- **Risk stratify** all empanelled patients
- **Targeted, proactive, relationship-based care management** to all patients identified as at increased risk and who are likely to benefit from intensive care management
- **Short-term care management with medication reconciliation** to high and increasing percentage of empanelled patients who have a hospital admission/discharge/transfer and who are likely to benefit from care management
- **Patients with ED visits** receive a follow up interaction within one week of discharge
- Contact **at least 75%** of patients who are hospitalized in target hospital(s) within 2 business days

Requirements for Track 2

- Use a **two-step risk stratification** process for all empanelled patients
- Use a **plan of care** centered on patient’s actions and support needs in management of chronic conditions for patients receiving longitudinal care management

- **Integrated with enhanced health IT for Track 2**

Track 2 capabilities are inclusive of and build upon Track 1 requirements.
Episodic and Longitudinal Care Management

Longitudinal

- Systematically risk stratify empanelled population
- Proactively monitor
- Co-manage care with specialists
- Self-management support
- Long-term, personalized care management using care plan

Episodic

- Event triggers
- Follows-up with patients post discharge
- Accurate information shared across care settings (hospital to home, hospital to skilled nursing facility)
- Medication reconciliation
- Short-term care management support
Risk Stratification

What is the aim of risk stratification?
Identify patients who are most likely to benefit from care management to improve health outcomes, reduce harm and waste, and reduce unnecessary utilization.

Why two-step risk stratification?

1 Algorithm
- Includes set of defined criteria
- Criteria may include:
  - High risk chronic conditions
  - Multiple diagnoses
  - Multiple pharmaceuticals
  - Frequent hospitalizations/ER
  - Mental health diagnosis
- Each patient assigned a risk score

2 Clinical Intuition
- Applied as needed or identified
- Criteria may include:
  - Psychosocial issues
  - Health literacy
  - Family/Caregiver limitations
  - Chronic or health issue not accounted for in algorithm
- Care team may modify risk score or category
Longitudinal Care Management

- Low Risk
- Moderate Risk
- High Risk

Target, Proactive Support
Relationship Based
Ongoing, Regular Touch
Guided by Care Plan
Episodic Care Management

What is an “episode of risk”? Examples can include: transition from hospital, new diagnosis or injury, or exacerbation or clinical instability in a chronic condition.

Example: Practice is notified that patient was seen in ED. Episodic care management activities may include:

- Medical reconciliation
- Communication protocols
- Follow-up tests and services
- Transfer information when site of care changes
- Changes in plan of care
- Education of the patient and family
- Involvement of care team
Enhancing Care Management through Health IT

- Empanel patients to care team
- Risk-stratify practice site patient population
- Identify and flag “Patients with Complex Needs”
- Establish a patient-focused care plan to guide care management

Continuous Quality Improvement
Learn More about Care Management

CPC+ Requirements

CPC+ Roadmap

CPC+ Change Package
Engage with the CPC+ Learning Community on Care Management

- Review the Change Package and Care Delivery Requirements
- Find tools and resources in your Implementation Guide
- Join Action Groups
- Ask questions and share best practices on CPC+ Connect
Upcoming CPC+ Events

Check the CPC+ Community’s Weekly Update for registration details as they become available.

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<tr>
<th>Webinar Topics</th>
<th>Scheduled Date</th>
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<tr>
<td>UPDATED: Health IT Office Hour</td>
<td>February 8, 2017 at 4:00 pm ET</td>
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<td>Comprehensiveness and Coordination</td>
<td>February 16, 2017 at 4:00 pm ET</td>
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<tr>
<td>Planned Care and Population Health</td>
<td>March 2, 2017 at 4:00 pm ET</td>
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<tr>
<td>Requirements, Reporting, and Monitoring</td>
<td>March 8, 2017 at 4:00 pm ET</td>
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<td>Patient and Caregiver Engagement</td>
<td>March 16, 2017 at 4:00 pm ET</td>
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<tr>
<td>Continuous Improvement Driven By Data</td>
<td>March 22, 2017 at 4:00 pm ET</td>
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Recordings of events are available on CPC+ Connect approximately a week after the live delivery.

Join Us! We will hold an Open Office Hour session the last Thursday of every month at 4:00 pm ET
Additional Questions?
Contact CPC+ Support at 
CPCPlus@telligen.com or 1-888-372-3280
Thank You

We appreciate your feedback on this learning event. Please take a minute to complete our survey.