
# CARE DELIVERY INTERVENTIONS GUIDE

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# Acronyms

| Acronym | Term |
|---|---|
| AIMS | Advanced Integrated Mental Health Solutions |
| AHRQ | Agency for Healthcare Research and Quality |
| BH | behavioral health |
| BHI | Behavioral Health Integration |
| CMS | Centers for Medicare & Medicaid Services |
| CoCM | Collaborative Care Model |
| DME | durable medical equipment |
| e-Consults | Electronic Consultations |
| ED | Emergency Department |
| EHR | electronic health record |
| HVCC | High Value Care Coordination |
| IHI | Institute for Healthcare Improvement |
| MDD | major depressive disorder |
| DM2 | diabetes mellitus type 2 |
| PCF | Primary Care First |
| PCMH | Patient-Centered Medical Home |
| PFACs | Patient and Family Advisory Councils |
| SAMHSA-HRSA | Substance Abuse and Mental Health Administration–Health Resources and Services Administration |
| SIP | Seriously Ill Population |
| SMS | self-management support |
| SDM | shared decision-making |
| SDOH | social determinants of health |

# Care Management

Care Management supports patients with complex care needs. All practices participating in Primary Care First are expected to provide targeted care management, using risk stratification approaches to identify those individuals most likely to benefit. PCF practices in Groups 3 and 4 serving a population with increased health and social complexity and SIP practices, will need to invest more deeply in care management by engaging high-risk beneficiaries in personalized care planning and ensuring that beneficiaries receive appropriate services from other healthcare providers (e.g., durable medical equipment [DME] items and services).

## *What Are the Primary Care First Care Management Activities?*

- Risk stratification
- Care management, including personalized care planning
- Timely follow-up after Emergency Department (ED) visits and hospitalizations

**Care Delivery Interventions**

- **All Practices:** Provide risk-stratified care management for all empaneled patients with complex needs and likely to benefit.
- **PCF Groups 3 and 4 and SIP Practices:** Collaborate with all high-risk patients to develop and maintain documented personalized care plans addressing their goals, preferences, and values.
- **All Practices**: Ensure all patients receive timely follow-up contact from your practice after ED visits and hospitalizations.

## *Risk Stratification*

### Why Is Risk Stratification Important?

Risk stratification enables practices to target resources to patients demonstrating the greatest needs and most likely to benefit. It is a dynamic process that allows a practice to maintain a perspective of the entire patient population while developing strategies to address those patients at high and/or rising risk. Assigning a risk status or score to each empaneled patient should give practices an actionable view into the needs of their patient population.

### What Are Effective Risk Stratification Strategies?

Risk stratification is a systematic approach to define risk of harm or adverse health outcomes for individuals in your practice population, particularly to identify patients who are at increased and rising risk and most likely to benefit from targeted, proactive, relationship-based care management and other strategies.

Algorithm-based risk stratification using structured data alone is efficient but often misses patients (up to 20 percent) who might benefit from care management services.[11] The addition of clinical intuition (i.e., practitioner and care team judgment) adds sensitivity and specificity to the identification of these patients by incorporating the care team's knowledge of patients and context[12] and significantly improves the ability of practices to find those patients most at risk of serious adverse health events.[13] Successful practices implementing risk stratification:

- **Select a risk stratification algorithm or process.** Practices have effectively used claims data, diagnoses clusters, clinical data in structured fields within the electronic health record (EHR), and combinations of the above to stratify their population according to risk. In choosing and weighting the data elements in the risk stratification algorithm, the practice is identifying those factors that they believe drive adverse outcomes in their population and that they can act on through care management and other strategies.
- **Add clinical intuition/care team perception to refine the identification of risk.** This adds a step in the process in which clinical judgment can be used to adjust the risk score based on information that is not available through the structured fields and data sources used in the algorithm. In some practices, this is a formal process with pre-defined criteria and in others it is more intuitive; information might include patients' social needs, health literacy, activation, family or caregiver support, or a behavioral or medical need not accounted for in the algorithm.
- **Embed the process within the health IT system and monitor and refine regularly.** Some practices use functionalities built into their EHR or additional health IT systems integrated with their EHR. Attempt to automate as much of the process as possible and build adaptable systems that can adjust risk as new information is available.

## Useful Resources

- Risk Status Assignment Practice Implementation Guide (2014)
    - Developed by HealthTeamWorks, this guide describes common risk stratification methods and provides a sample method for risk stratification that can be used in primary care practices.
- Risk Stratification Methods and Provision of Care Management Services in Comprehensive Primary Care Initiative Practices (2017)
    - This article from the *Annals of Family Medicine* describes risk stratification patterns and their association with care management services for primary care practices in CPC Classic. The authors review four primary methods CPC practices used to stratify their patient populations.
- Implementing Risk Stratification in Primary Care: Challenges and Strategies (2019)
    - This article from the *Journal of the American Board of Family Medicine* is a study of risk stratification processes in primary care practices. The authors review three decisions that are important in shaping practices' experiences with risk stratification, challenges associated with those decisions, and practice successes in implementing risk stratification.
- Predict, Prioritize, Prevent – Nine Things Practices Should Know About Risk Stratification and Panel Management (2013)

- This issue brief, developed by the Colorado Beacon Consortium, describes nine things practices should know about risk stratification and panel management, including the purpose of risk stratification, use of data and clinical intuition, and impact on workflow.

## *Care Management*

### Why Is Care Management Important?

Care management is a process of working with patients, generally outside of face-to-face office visits, to help them understand and manage their health, navigate the health system, and meet their health goals. Practices working with patients who have complex care needs have found care management to be an effective and necessary strategy for mitigating risk and improving health outcomes.

### What Are Effective Care Management Strategies?

Care management is a resource-intensive intervention and will have its greatest impact when it is targeted toward those most likely to benefit. Practices have found it valuable to think in terms of two broad types of patients who might benefit from different approaches to care management:

- Patients with some combination of multiple comorbidities, complex treatment regimens, frailty and functional impairment, behavioral and social risks, and serious mental illness often benefit from long-term, proactive, and relationship-based **longitudinal care management**.
- Patients who are otherwise stable will benefit from short-term, goal-oriented **episodic care management** during periods of increased risk like transitions of care; diagnosis of a new, serious illness or injury involving complex treatment regimens; or newly unstable chronic illness.

***Longitudinal Care Management.*** Successful practices use on-site, non-physician, practice-based, or integrated shared care managers to provide longitudinal care management for the highest risk cohort of patients, with assistance from other practice staff, as needed. Multiple team members may engage in care management, but each patient identified as eligible should have a clinically trained individual in the practice who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment.[14] Longitudinal care management:

- **Is captured in structured fields within the EHR or additional health IT systems.**
- **Includes providing proactive care that moves beyond traditional office visits or crisis-driven care (e.g., ED care or hospitalization) and is not primarily visit-based.** Although office visits are opportunities to define goals, plan patient care, engage in shared decision making, and build a trusting relationship, most care management

activities take place by phone, patient portal, e-mail, mail, or home visits (and through visits to skilled nursing facilities or hospitals to support transitional care).

- **Includes a process of personalized care planning.** The personalized care planning process helps practices engage and collaborate with patients to ensure that their care aligns with patient preferences, goals, and values.[15,16]
    - A **care plan** is a mutually agreed-upon document that outlines the patient's health goals, needs, and self-management activities and is accessible to all team members providing care for the patient. The care plan should be patient-friendly, accessible to the patient, and should limit use of unfamiliar medical jargon and acronyms. The care plan should also be structured and standardized, documented within the practice's health IT to enable sharing among patient, caregivers, and care team members.

      **Critical Elements of a Care Plan May Include:**

      - Treatment goals and interventions
      - The patient's overall health goals and an action plan to achieve those goals
      - Advance directives and the patient's preferences for care
      - Key contact information for the practice
      - Actions that the patient and their care team will be taking, and the most important contingencies (e.g., "if/then" for the specific patient and their conditions).
    - All high-risk patients receiving longitudinal care management should have a personalized care plan developed in a joint, open-ended conversation between the patient and care team.
    - Personalized care planning is a dynamic process; therefore, the care plan document should be updated at regularly defined intervals by the care team and patient. In addition, when patients' health status, preferences, goals, and values change, their plans of care should, too.

***Episodic Care Management.*** **Practices use the concept of Episodic care management to identify patients who have acute or urgent needs using "triggering events"** (e.g., hospital discharge, new diagnoses, medical crisis, major life event, decompensation in otherwise controlled chronic condition) for short-term, problem-focused care management services. Episodic care management is generally time limited and problem focused and most often includes coordination of services and follow-up, patient education and support for self-management, and medication reconciliation.

## Useful Resources

- CPC+ Personalized Care Planning Video (2018)
    - This CMS on-demand animation, developed for CPC+ participants, guides practices through a set of core elements to consider during care planning implementation and to build on based on patients' needs.

- Michigan Care Management Resource Center (Retrieved in 2019)
    - Developed by the Michigan Institute for Care Management and Transformation, this site provides guides and toolkits for care management, including resources for care manager training, chronic condition management, transitions of care, and more.
- Care Management: Implications for Medical Practice, Health Policy, and Health Services Research (2015)
    - Developed by the Agency for Healthcare Research and Quality, this issue brief highlights three key strategies to enhance existing or emerging Care Management programs.

## *Timely Follow-up after ED Visits and Hospitalizations*

### Why Is Follow-up after ED Visits and Hospitalizations Important?

The flow of patient information between transition care settings is often limited,[17] and primary care practices are often uninformed about the transitions in care when patients are discharged from EDs and hospitalizations. Without appropriate post-discharge follow-up and referral management, patients are at risk for post-discharge complications and worsening of their conditions.[18]

### What Are Effective Strategies to Achieve Timely Follow-up after ED Visits and Hospitalizations?

Key aspects of follow-up after ED visits and hospitalizations include **identifying and partnering with target hospitals and EDs where the majority of a practice's patients receive services to achieve timely notification and transfer of information** following hospital discharge and ED visits. When developing a standardized process for data exchange and timely follow-up, successful practices include the following processes:

- Information and data exchange about patients seen in an ED or admitted to/discharged from a hospital (e.g., via health information exchange [HIE], hospital portal, hospital-generated report, her, or additional health IT system)
- Definition for "timely" follow-up after discharge (e.g., no later than within 2 days of discharge from hospital admission or observation stay and within 1 week of discharge from the ED)
- Protocols for when follow-up will be done (e.g., before discharge or following a standardized follow-up protocol)
- Process of incorporating into the patient's medical record so the information is available at the time of the follow-up visit or other patient contact

- Practices should use standardized processes and protocols for data exchange and formalized partnerships to develop an efficient workflow to ensure timely follow-up and facilitate efficient and safe transitions of care.

## Useful Resources

- Timely Exchange of Hospital and Emergency Department Data (2017)
    - A presentation on sources of hospital and emergency department (ED) data and how to identify processes for improving hospital and ED follow-up