# VALUE TRANSFORMATION FRAMEWORK
## *Action Guide*

### HEALTH CENTER

| CARE DELIVERY | INFRASTRUCTURE | PEOPLE |
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# POPULATION HEALTH MANAGEMENT
## MODELS OF CARE

# WHY
## Design Different Models of Care Based on Risk Level?

Population management is key to successful value-based care. Effective population health management requires that health care organizations group patients based on their needs to direct care and target resources (See *Risk Stratification* Action Guide). Top performing health centers segment patients by risk and design models of care tailored to each subgroup. The purpose is to offer more appropriate and cost effective care to patients who fall into different levels of risk, rather than using a "one size fits all" approach. Identifying unique subgroups of patients, and analyzing each group's health needs, trends, and outcomes, allows health centers to best intervene for improved outcomes.

# WHAT
## are Care Models Based on Risk?

Designing care models based on risk allows patients to be paired with more appropriate clinical and other services. This Action Guide outlines approaches to building models of care for high, rising and low-risk target populations. Models for highly complex patients are very specialized and
not addressed here.

- **High-risk** patients are assigned a care manager who coordinates care across the continuum.

- **Rising-risk** patients are managed within the Patient Centered Medical Home (PCMH) model, with scalable strategies to manage their immediate needs and prevent them from becoming high-risk.

- **Low-risk** patients are managed with more remote, group, and technological solutions. Strategies may include care other than in-person visits, including self-care.

## POPULATION HEALTH MANAGEMENT

within the Value Transformation Framework speaks to the systematic process of utilizing data on patient populations to target interventions for better health outcomes at lower cost, with a better care experience. This Action Guide outlines a framework for the design of unique models of care to subgroups of the population identified through risk stratification.

| CARE DELIVERY | INFRASTRUCTURE | PEOPLE |

# POPULATION HEALTH MANAGEMENT
## MODELS OF CARE

## HOW
### to Design Models of Care Based Upon Risk

While the Patient Centered Medical Home (PCMH) model serves a vital role in advancing patient-centered, comprehensive, and coordinated care, it does not specifically call-out segmenting patient care around risk. An approach that includes risk stratification and differentiated care is required to deliver care more efficiently and reach value-based goals.[2,3,4,5] A single model of care does not meet the full continuum of needs across a patient population. The PCMH model is best suited for the vast majority of rising-risk patients who fall between the low and high risk groups, but not necessarily for patients who fall into low or high-risk categories. To achieve value-based goals, care models should enable clinical staff to work at the top of their licensure, with training in population health management, risk stratification, and care competencies for different risk-categories. Successful care models also require infrastructure for clear, two-way communication loops from outside specialists and points of care (e.g., hospital) that ensure streamlined patient care and services.

### CARE MODEL ACTION STEPS:

This Action Guide outlines a framework for designing unique models of care for sub-groups of the patient population:

- **High-Risk Care**
- **Rising-Risk Care**
- **Low-Risk Care**

*To achieve the benefits of each care model, a health center must aim to successfully complete the action steps outlined in the Leadership, Care Team and Risk Stratification Action Guides, with Risk Stratification as a pre-requisite.*

# POPULATION HEALTH MANAGEMENT
## MODELS OF CARE

### High-Risk Care Model

The goal in the high-risk care model is to provide individualized care plans to address the patient's full range of issues from chronic disease to behavioral health and non-clinical issues. This Action Guide assumes the use of an RN care manager, although other staffing models can be utilized. The Care Manager's importance as the central coordinating figure in managing care for high-risk patients cannot be overstated. See the *Care Team* and *Care Management* Action Guides.

**Action item: Complete Risk Stratification.** Start by identifying the health center's high-risk cohort. The Care Manager may decide to further triage subgroups for initial focus (e.g., to target specific age groups or populations of focus, such as opioid addicts or those in need of a preventive service).

The target caseload for an RN Care Manager will vary depending on a number of variables but is likely in the range of 50-150 high-risk patients.[6] Factors affecting caseload size and complexity include health center environment, experience of the care manager, the clinical and social complexity of patients, available social supports, and target care management outcomes.[7] Caseload size and manageability should be evaluated on an ongoing basis.

**Action item: Identify a Care Manager.** The Care Manager is the central point of contact for the pool of high-risk patients. This individual will be accountable for coordinating care in partnership with the care team and across the care continuum. This includes consideration of non-clinical, social risk and other issues.

**Action item: Build A Care Management Model.** Define a standardized approach for individual patient care plans that includes templates and documentation capabilities within the health center's electronic health record. The care model includes assessment of social risk to determine non-clinical issues that may impede care. Non-clinical issues can be addressed by the care manager as part of an individualized care plan. A comprehensive care plan that addresses clinical and non-clinical issues will require partnerships with outside organizations.

**Action item: Begin Enrollment of High-Risk Patients into Care Management.** A warm handoff and introduction of a patient to the care manager by the provider is a best practice.[8] Alternatively, the care manager may initially reach out via phone or letter to a patient indicating their provider has recommended the patient for care management. The Care Manager then coordinates a comprehensive clinical and non-clinical assessment of the patient, and a visit with provider – culminating in an individualized care plan. Care plans should include steps for patient engagement in self-care. See *Patient Engagement* and *Care Management* Action Guides.

# POPULATION HEALTH MANAGEMENT
## MODELS OF CARE

**Action item: Partnerships.** Care Managers should develop a list of community resources and partners who the patient and care team will interface with in carrying out a plan of care. Some high performing health care organizations coordinate with providers who follow-up high risk patients in their home, or support a patient's use of telehealth, or other self-care activities.

## Rising-Risk Care Model

The goal in the rising-risk model is to improve this target population's health outcomes while reducing costs, and prevent these individuals from escalating to the high-risk category. While services such as care coordination are valuable with this group, extending the high-risk care management model to this group is not clinically necessary and often inefficient. This is where full deployment of the PCMH model, and team-based approaches to care, come into play.

**Action item: Complete Risk Stratification.** After segmenting patients into four risk categories (highly complex, high, rising, and low-risk), identify all patients with three or fewer of the select UDS chronic conditions (or other threshold set by your health center). Where data exists, consider risk factors such as obesity, depression, HTN, high cholesterol, elevated blood sugar (pre-diabetic), and tobacco use.

**Action item: Fully deploy the PCMH model.** To maximize the impact of the PCMH model, health centers can look for opportunities to scale interventions across the rising-risk group. To make the most of resources, efforts can include shared care offerings, the engagement of patient influencers (family or friends), and extra support for care transitions. Strategies for engaging patients and families in the design and function of the medical home can occur at three levels: care for the individual patient, practice improvement, and policy design and implementation.[9] Specific actions that can be taken to engage patients at the health center level include: decision aids on the role of patients and care team members in PCMH, self-care support, shared decision-making, visit summaries and written care plans, and patient surveys.[1] See *Care Teams* Action Guide.

Strategies for addressing the needs of rising-risk patients include review of gaps followed by targeted outreach and scheduled annual or follow-up visits for chronic diseases that incorporate preventive screenings (cancer, HTN, diabetes, obesity, and depression), particularly when the patient is invited to bring a family member or friend to serve as an advocate and 'influencer'. The 'influencer' serves as an extension of the care team and, importantly, notifies the team when significant events or transitions occur. Some organizations have also effectively incorporated the use of patient navigators or health coaches to address care coordination, including prevention screenings.

# POPULATION HEALTH MANAGEMENT
## MODELS OF CARE

**Action item: Deploy new care interventions.** During face-to-face visits, rising-risk patients may be invited to try new approaches to their care. This includes group visits, online communities, patient influencers and tightly managed transitions with a health coach.[3] Surveys indicate that influencers such as friends, family and caregivers are willing and eager to help educate and engage in their loved-one's care.[3,9] If your electronic health record allows, offer the opportunity to share a portion of the patient's medical record, or care plan, with families and caregivers. There is also a secondary benefit to engaging influencers. Family and friends of chronically ill individuals often share the same behaviors, and they too may benefit from the education and planning provided to patients.[3]

## Low-Risk Care Model

The goal for this population is to modify the care delivery model so that low-risk patients can readily receive services through alternative access points (e.g., telephone, patient portal, etc.) and less often through face-to-face provider interactions. Prevention and care needs are provided in ways that are efficient, satisfying to the patient, and less costly for the patient and provider.

**Action item: Complete Risk Stratification.** Identify all patients not included in either the high or rising-risk groups (e.g., low risk).

**Action item: Design new interventions that serve low-risk individuals who are healthy or have a mild condition that does not require intensive follow-up.** Provide new access points for these patients. Consider using the patient portal as the primary means of communication with this group. Reserve provider interaction for critical prevention milestones and unexpected care needs.

Preliminary studies on the impact of virtual access points show that portal access increases overall patient engagement with the health system. This is important, because even with the highest standards of efficiency, a primary care physician would need 7.4 hours per working day just to satisfy the US Preventive Services Task Force recommendations alone – not accounting for other health care needs.[10] Therefore, designing a strategy for patient portal engagement is critical for this cohort. Proactively educate patients about new and evolving low acuity access points.

**Action item: Create ways to retain and satisfy low-risk patients.** As outlined above, patient portals, if effectively deployed, have been shown to be effective and a loyalty driver for patients. Explore additional ways to deploy technology and other strategies for reaching this target population.

# POPULATION HEALTH MANAGEMENT
## MODELS OF CARE

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