ACCOUNTABLE CARE
LEARNING COLLABORATIVE
AT WESTERN GOVERNORS UNIVERSITY

A Call for Collaborative Action

Identifying Required Competencies for Success in Value-Based Care

PATIENT RISK ASSESSMENT

ACLC Whitepaper Series

Governance & Culture
Financial Readiness
Health IT
Patient Risk Assessment
Care Coordination
Quality
Patient Centeredness

INTRODUCTION

The country is at an inflection point in how it pays for and delivers health care services. While much of the recent policy focus has been on payment reform, insufficient attention has been given to delivery reform. Public and commercial payers alike are increasingly adopting value-based payment agreements whereby providers are either financially rewarded or at financial risk, depending on whether they meet predetermined quality and spending outcomes. These payment models tell providers the quality or spending outcomes for which they are accountable, but they do not explain what the provider needs to do, or do differently, in order to achieve these goals.

In an industry-wide effort to assist providers with care delivery changes the Accountable Care Learning Collaborative (ACLC) has identified a core group of essential competencies that providers will need to develop in order to succeed in value-based care. The ACLC is introducing these competencies, in conjunction with a framework, as a starting place. We invite payers, providers, and the larger value-based care community to participate with us in evaluating and refining these competencies to help improve all providers' proficiencies under value-based agreements.

The patient risk assessment whitepaper, part of the inaugural ACLC whitepaper series, highlights patient risk assessment-specific competencies identified by the ACLC Patient Risk Assessment Workgroup and provides an explanation of the domain, value, methodology, and findings.

Additional whitepapers, the full list of competencies, and instructions for public comment can be found at **AccountableCareLC.org**.

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WHY PATIENT RISK ASSESSMENT IS ESSENTIAL

In 2009, the Centers for Disease Control and Prevention (CDC) estimated that nearly 38% of all physician office visits were made by adults who had multiple chronic conditions. In context, this represents an estimated 326 million of the nearly 868 million physician office visits made by adults that year.[1] As the population ages, this number increases: three in four Americans 65 or older have multiple chronic conditions.[2]

In the transition from volume to value-based care, the prevalence of multiple chronic conditions is only one challenge in achieving the Triple Aim: improving patient experience; improving the health of populations; and reducing health care costs. The patient risk assessment process is essential in helping to efficiently allocate health care resources. Risk assessment, leading into appropriate care, case, and population management models, is vital in reducing the fragmented, inefficient, incomplete care that individuals may experience because it allows providers and organizations to view a more holistic picture of each individual. In turn, holistic views through patient risk assessment facilitates increased attentiveness to otherwise overlooked but important factors such as demographic, psychosocial, and physical needs of the patient.

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METHODOLOGY

Literature Review

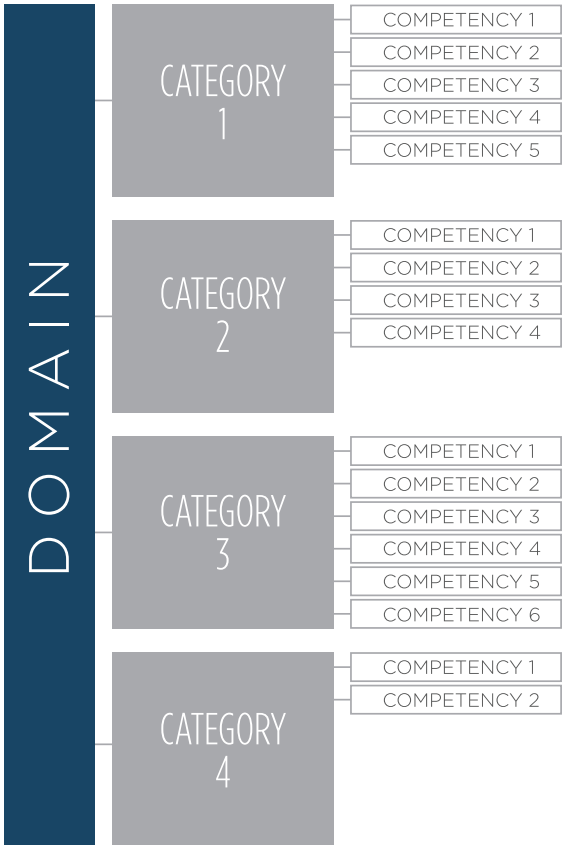
The ACLC research staff utilized a structured approach to identify a list of competencies for each domain. The first step involved the review of various frameworks and literature geared toward preparing providers to bear financial risk. Through a qualitative analysis, the staff identified common themes of competencies and mapped out language differences and commonalities to reveal general industry agreement on seven competency 'domains.' Preliminary sub-domains or 'categories' were created to organize competencies into more manageable groups for review and refinement (e.g. 'Ease of Access' category under the 'Patient Centeredness' domain). A second literature review was then conducted based on the seven domains, scanning for specific guidance on categorization schemes and distinct competencies within each domain. Initial competency domains and categories were then offered to ACLC members for their review.

ACLC Domains

- Governance and Culture
- Financial Readiness
- Health IT
- Patient Risk Assessment
- Care Coordination
- Quality
- Patient Centeredness

Workgroup Review and Refinement

Commensurate with the number of domains, seven workgroups were assembled to provide multi-stakeholder review of the preliminary research and give further direction. Each workgroup was chaired by an individual nationally known for expertise in the domain and comprised of ACLC members who indicated specific interest or expertise in a domain. Workgroup members were then given documents that contained the full literature review and analysis along with access to the original documents for reference. Virtual and in-person workgroup meetings were held to review sources, create and refine domain titles and categories and to develop descriptive narrative language for each. Additional vetting and refinement of the domains, categories, and specific competencies was accomplished via email and conference calls. Specific attention was given to recognize and resolve overlap between and among competencies. Workgroup chairs held additional meetings to review proposed competencies, coordinate content, and identify overlap.



WORKGROUP CONCLUSIONS

Domain

In defining patient risk assessment, the workgroup began by evaluating generally accepted risk assessment industry standards. Generally, risk assessment has been limited to guiding care management and coordination activities. The movement to value-based care requires a more expansive application of risk assessment to maximize its value.

The workgroup participants considered the definition of both risk assessment and risk stratification: that is the individual patient's health risk or risks and the population's risk stratified, respectively. Factoring both components are essential in managing provider spending and provider staffing resources or in sum achieving accountable care. Under the domain name "Patient Risk Assessment," the workgroup proposed the following definition:

"Patient risk assessment is the determination that an individual needs help managing chronic conditions (care management) or navigating the complex system with multiple points of care (care coordination) or both. Proper patient needs assessment and assignment allows for the use of specific strategies and resource allocation to better serve and provide 'value' at the patient and population level. Prospective patient risk assessment models parallel and align with care management and care coordination design and activities."

Categories

The workgroup recognizes that a complete list of competencies is difficult to evaluate. In order to make evaluation of available competencies most efficient, the workgroup created a multi-part categorization scheme. **These categories present a framework by which providers may quickly identify groups of competencies for which they seek additional understanding.** Below are the four categories with accompanying definitions and the corresponding number of competencies in parenthesis:

1. **Platform (7):** The platform is the system of hardware, software, and processes which enable and support analysis, visualization, and best practices to assess and stratify a population with the intent to identify specific care needs and/or opportunity for health outcomes improvement, at both the population and individual patient level.
2. **Risk Assessment Data (11):** Patient-specific sociodemographic, utilization history, clinical and behavioral health information collected from a variety of sources that serves as the basis for determining an individual patient's need for additional services and the level of risk associated with that patient.
3. **Implementation and Data Processing (5):** The process workflow of managing current data through the platform in order to determine the patient risk index based on predefined rules and algorithms in order to support a personalized best care pathway for the quality treatment of each patient on a timely basis.
4. **Risk Monitoring and Reporting (4):** Timely, meaningful, and actionable reports providing both population and patient level data to prioritize interventions by levels of risk and identify areas of needs that can improve patient care and patient-oriented outcomes. The risk reports will inform the choice of intervention(s) through stratification tiers based on risk and provide patient-level drivers for each level of risk.

It is important to note that although these are the categories that made sense to this particular group of commissioned reviewers, the ACLC expects providers to redefine and/or add to these categories such that they are more applicable to their unique circumstances.

Competencies

The patient risk assessment workgroup has identified 27 competencies. The list of competencies is by no means exhaustive. We welcome further investigation and additions by other groups and individuals and we hope this current list will provide a good foundation for that work. We refer the reader to the full competency list in the table below, but include one example from the workgroup discussion here for illustrative purposes.

Patient risk assessment has traditionally been focused solely on identifying the financial risk of seriously chronically ill patients based on claims data. However, to best understand the needs of these patients, additional data sources, particularly non-clinical data sources, are essential. The State of Ohio has developed a robust risk assessment protocol for its MyCare Ohio Dual Eligible Special Needs Plans. The Ohio program employs a risk assessment approach that ensures patient care plans are more complete by including health risk assessments, functional assessments, and referrals from family members, providers and the patient, instead of relying solely on claims data.[3]

CATEGORY	COMPETENCY LABEL	COMPETENCY
PLATFORM	PRA.1.1	Implement a patient risk assessment and stratification methodology that incorporates multiple data types, including administrative, clinical, and patient-reported data
	PRA.1.2	Support multiple levels of analysis, such as population and individual patient levels of analysis
	PRA.1.3	Identify targetable behaviors and interventions based on specific patient needs and multiple program models
	PRA.1.4	Enable user defined variable weights and models for multiple care models or programs
	PRA.1.5	Customize the platform to align with organizational support and resources by allowing variable weighting for multiple care models or programs
	PRA1.6	Design the platform to address the diverse needs of the population served
	PRA.1.7	Adapt risk assessment models in response to patient need, business use, or payment incentives

Competencies (cont'd)

CATEGORY	COMPETENCY LABEL	COMPETENCY
RISK ASSESSMENT DATA	PRA.2.1	Identify diagnoses and patient needs that both drive spending and are modifiable
	PRA.2.2	Utilize clinical data available to the risk-bearing provider entity for risk assessment, such as claims, utilization data, clinical encounter data, EMR extracts, hospitalizations, lab testing, and pharmacy data
	PRA.2.3	Keep risk assessment data sources and information updated
	PRA.2.4	Evaluate and use demographic information for assessing patient risk
	PRA.2.5	Determine which patients are appropriate for risk assessment based on the patient's behavioral or mental health history, functionality, physical limitations, co-morbidities, frailties, and participation in palliative or end of life care
	PRA.2.6	Develop a process to use clinical notes for risk assessment
	PRA.2.7	Evaluate the patients' socioeconomic information, including the support received from family and caregivers and social isolation in assessing risk
	PRA.2.8	Incorporate referrals and patient notes from a variety of outside sources into your risk assessment, including care management, community resources, hospital discharge planner, family, etc.
	PRA.2.9	Incorporate patient-reported information in risk assessment
	PRA.2.10	Use physician input in risk assessment
	PRA.2.11	Evaluate limitations that increase patient risk, including language barriers, hearing, vision, and mobility
IMPLEMENTATION & DATA PROCESSING	PRA.3.1	Evaluate the quality of the data input for the risk assessment algorithm
	PRA.3.2	Ensure competent staff to run stratification data and reports
	PRA.3.3	Validate risk assessment tool periodically
	PRA.3.4	Integrate risk data with appropriate clinical evidence-based guidelines
	PRA.3.5	Use available data at the point of care to inform care decisions
RISK MONITORING & REPORTING	PRA.4.1	Create a user-friendly report profile which is interactive and easily modifiable
	PRA.4.2	Allow segmentation by filters (e.g. payer, provider, health condition, psychosocial or behavioral health, etc.)
	PRA.4.3	Monitor the rising risk index of patients and sub-populations
	PRA.4.4	Provide transparency and access to risk reports throughout the risk-bearing provider entity

NEXT STEPS

The patient risk assessment information presented in this paper is a starting point and marks the beginning of a public comment period. The ACLC will release a series of subsequent revisions as comments and the perspective of future members are reviewed and incorporated. It is anticipated that the work will substantially evolve over time as more information, evidence, and perspective is acquired.

There is more to do than just refine the domains, associated competencies, categories and definitions inventoried here. Going forward the ACLC will begin identifying stages of competency attainment, recognizing that not all competencies can or should be advanced simultaneously. ACLC members will also begin stratifying competencies by the type of organization and risk arrangement. For example, an integrated health care system will have a different starting point and possibly end goals than a single practice specialty group. The ACLC will also create a resource center where evidence including case studies, vendor information, and other relevant materials will be available and disseminated, all with the goal of advancing and accelerating the successful adoption of value-based care arrangements.

To provide comments to the work of this workgroup or others and to learn more about how you can help contribute to this shared body of knowledge, please visit AccountableCareLC.org.

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About the Accountable Care Learning Collaborative

The ACLC accelerates the transition to accountable care by identifying what providers need to succeed in value-based payment models. Through collaborative forums, members contribute their understanding and experience in the real world of accountable care implementation. The ACLC is managed by Leavitt Partners, LLC.

About Western Governors University

The ACLC is at Western Governors University (WGU), a leading innovator in health care education. WGU offers over 50 online bachelor's and master's degree programs that are accredited, flexible and competency based, serving the needs of working adults. Degree programs include nursing, health informatics, business administration, and integrated health care management. WGU prepares future leaders for the world of accountable care.

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