ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

COMPETENCY ORIENTATION GUIDE

Competency: Analyze risk-relevant information to inform risk profiles and corresponding care delivery efforts

Committee: The Committee on Risk Stratification

AUGUST 2019

BACKGROUND

The Accountable Care Learning Collaborative is a non-profit organization dedicated to accelerating the transition to accountable care by identifying the care delivery competencies needed for providers to succeed in risk-based payment models. The Competency Orientation Guides (COGs) serves as an overview of a particular competency and are intended to help break down the competency into more digestible aspects that could be implemented in a variety of ways. Each COG represents the distilled insights from the deliberations of a dedicated committee comprised primarily of leaders from provider organizations, but also industry partners, and ACLC research staff. In this case, this COG was developed by the Committee on Risk Stratification (the "Committee") which convened between March and May of 2019. on Value-Based Contracting which convened between January and May of 2019.

Competency Framework

1. Clear Vision & Strategic Direction
2. Technical Infrastructure Needed
3. Model Building
4. Intervention Identification
5. Operationalizing
6. Ongoing Monitoring & Improvement
7. performance
8. Model potential performance under the contract

COMPETENCY IMPORTANCE & CONTEXT

As organizations commit to contracts requiring accountability for population cost and quality outcomes, care teams are looking for ways to prioritize and strategically deploy their limited resources by targeting patients with the greatest impact potential. Risk stratification is an essential component of effective population health management, yet the industry lacks consensus on the best approaches for identifying at-risk patients and determining the optimal interventions. Importantly, the Committee clarified that, for the purposes of these discussions, this competency addresses patient-level risk stratification used to inform proactive care delivery interventions. Meaning, population stratification used to inform business decisions, as well as risk adjustment for the purposes of informing payment were outside of the scope of this committee.

IMPORTANT TERMS

While there are many definitions of risk stratification in health care, within the context of the focus competency, the Committee elected to use the following definition: The process of segmenting patients based on anticipated care needs/costs; matching the patient with an appropriate intervention and funding mechanism; engaging the patient prior to escalation.

COMMON ELEMENTS

1. Clear Vision & Strategic Direction

Committee Insights:

- More than just HIT, risk stratification touches the whole provider organization and therefore it is important to gather input widely when making decisions regarding risk stratification investments and strategies. Specifically, decision-makers should consider including clinical program leads, data analytics teams, frontline clinical staff/end users, utilization review staff, and internal individuals representing current solutions providers, among others.)
- When establishing a clear vision and scope for risk stratification efforts, organizations should consider several questions: Why are we doing this? What can we already do? How should we prioritize what we want to do better?
- Just as organizations must begin by assessing current stratification capabilities, this initial internal assessment must also include an evaluation of current care management capabilities. Where possible, align stratification priorities with proven interventions already in place.

Challenges:

- While it is important to gain buy-in from various departments and levels of the organization, approach these multi-disciplinary discussions with a level of rigor. All will come to the table with their own beliefs and expectations.
- Given the potential size of the investment (direct and indirect), organizations need the full support and commitment of senior leadership. The vision and direction for an organization's risk stratification strategy and solutions should be owned by a c-suite leader.

2. Technical Infrastructure Needed (Build vs Buy, Tools)

Committee Insights:

- When determining whether to build a risk stratification tool or buy from a vendor, provider organizations should consider the following:
  o Assess strengths of the current data team – Recruiting the talent necessary to build from start to finish (from inputs to outputs) is so costly. For this reason, building may be just as expensive as buying.
  o Determine what you want out of a vendor (e.g., utility vs. partner/consultant).
  o Understand the expense of transitioning platforms – Don't undervalue vendor connectivity. For example, a well-connected vendor with less than perfect analytics may be better than one with a strong predictive model but requires writing new interfaces for everything.
- When selecting a risk stratification vendor, don't look for perfection. Instead, identify vendors who are well-rounded and a collaborative and willing partner who will work with you to make targeted improvements.

Challenges:

- The vendor market is problematic and still immature; Still, buying may be favorable to building – at least in the beginning. (For example, starting with 'buy' is helpful to have something to show providers; See what they like and what they don't so you can eventually recreate the good parts.)
- Creating/customizing visuals can require provider to spend significant time manually manipulating vendor-generated outputs.

3. Model Building (Data, Inputs + Variables)

Committee Insights:

- Regardless of the accuracy of the predictive model, high-quality inputs are essential to any successful risk stratification strategy – "Garbage in, garbage out."
- Claims data are an imperfect data source (e.g., flawed, delayed), but a good starting place. You can do a lot with claims data alone. Get creative!
- Because claims data are flawed, providers must supplement/verify with clinical data from the EMR. Additionally, other supplementary sources, such as SDOH data, represent important opportunities for improved risk stratification and intervention pairing.
- It is important to discuss and understand data governance and to align with other providers, payers, and vendors on set definitions (e.g., what is a readmission?) – Is the information you're pulling, really what you think you're pulling?
- Clinicians don't need to understand the technical aspects of the predictive model, but they should know generally how it works and should feel responsible for helping to improve the inputs (through accurate tracking) and for supplementing the outputs with perceived risk.

Challenges:

- Incorporating multiple data sources will allow for the most complete picture of patient risk, but timeliness of data sources can be a challenge.
- While mental health and substance abuse issues have big implications for patients' potential care needs and challenges, much of this patient-specific data is difficult to share (e.g., 42 CFR). To address the structural and regulatory challenges around data sharing, some providers are using pharmacy data (e.g., antipsychotic meds) as a proxy.
- It can be difficult to balance the need to gain buy-in and build confidence in the risk stratification tool among the physicians and care team while also soliciting their critical review of the generated target list. Be willing to incorporate care team input/review of the risk stratification output – sometimes they know the patients best.

4. Intervention Identification

Committee Insights:

- Focus limited care management resources on priority patients with high impactability + receptivity.
- Make at least four outreach attempts (on different days and at different times) before determining a patient isn't receptive.
- Seek balance between standardization and customization by standardizing recommended pathways based on clinical best practice but allowing care managers to tailor care plans based on patients' preferences and needs.
- Inventory all resources/programs available through contracted payers to maximize existing supports and to coordinate patient touchpoints (e.g., ensure patient doesn't receive multiple satisfaction surveys, etc.).

Challenges:

- Just as it's important to remove patients who are medically inappropriate for targeted care management (e.g., traumas and one-off acute care, complex cases), risk stratification approaches should also attempt to focus limited resources on patients who are likely open/receptive to treatment. Evaluating a patient's receptivity is difficult and time consuming.
- Mental health and SDOH data limitations make it particularly challenging to tailor interventions according to patient needs or to equip care managers with the relevant information and resources.

5. Operationalizing

Committee Insights:

- The most critical element of risk stratification is translating risk information into action. When designing processes and systems to operationalize the risk data, organizations should consider, the optimal format and frequency of risk profiles/ reports; type and timing of information shared; internally-generated reports vs third-party product; integrating risk profile data in the EHR to make available at the point of care
- All stratification is done centrally, but practices/providers should be able to inform care for patients not identified, as well as ultimately accept or reject prioritization for care management.
- When building models/processes that will change workflows, seek feedback from the care teams who will be interacting with the data. In addition to multi-disciplinary care team, consider including Lean Six Sigma or process improvement experts to help with efficiency and maximize peoples' potential contributions.

Challenges:

- It can be difficult to determine what programs should be centralized for efficiency and alignment vs de-centralized to leverage existing infrastructures and expedite improvements.
- This work requires ongoing time and attention, even when analytics and reporting are automated (e.g., clinician education for improved documentation, practice-level evaluation and feedback/trainings, etc.).

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