A 4 Quadrant Risk Stratification Tool For Full Integration Care Management

Rafael Gonzalez-Amezcua, MD. Ramezcua@lacare.org
L.A. Care Health Plan. Los Angeles CA. www.lacare.org

Healthforce Center at UCSF

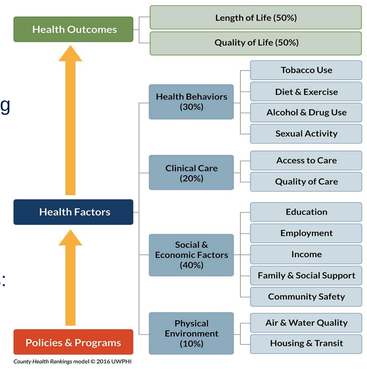
California Health Care Foundation

Problem Statement

Ensuring optimal health outcomes in complex dual eligible patients is challenging because the root cause of problems is often a combined product of multiple risk factors that PCPs are not able to address.

Initial Discovery

- Multiple factors impact health outcomes
- Clinical Care Impacts only 20% of outcomes
- LA Care's Care Managers primarily focus on clinical factors due to a lack of guidance in identifying and resolving other ranking risk factors
- PCPs have little time and few resources to address issues other than clinical care
- I developed a tool to guide a comprehensive assessment and integration of services with needs stratified, with patient input, into four risk categories: (Social, Functional, Medical, Behavioral)
- The prototype was well received by Care Managers and PCPs and tested via several PDSA cycles toward a final draft for wider testing



Mission Model Canvas

Key Partners

LA Care's internal departments:

1. Medicare Operations
2. Health Services
3. Community Outreach and Education
4. Health Outcomes and Analysis
5. Customer Solutions Center
6. Provider Network Management

Key Activities

1. Professional training for CM on the 4 quadrant tool and on patient engagement
2. Assign a specialized support team to CMs
3. Customer Solution Center helps deliver message to patients
4. Partner with PCPs

Key Resources

1. Member Benefit Guide
2. Social Workers, Long Term Services and Supports and Behavioral Health expertise
3. Family Resource Centers
4. Risk Stratification tools
5. Health Risk Assessments
6. Provider Handbook guide

Value Propositions

1. For LA Care's Care Managers: A new method to categorize incoming assessment data for enhanced identification of pts ranking needs and a better way to link need with service
2. For PCPs: A new method that gives more time for PCPs to address clinical issues with patients, while the Care Manager addresses other important patient needs
3. For patients: A new method to help identify and stratify impactful risk factors for better service delivery

Buy-in & Support

1. LA Care Executive leadership and support
2. Care Manager champion
3. Care Managers involved in the PDSAs
4. Identify training needs
5. For PCPs: respect and align with their workflows

Deployment

1. Care Managers will deploy the tool during usual patient encounters
2. Data from tool incorporated into Care Plan and presented to interdisciplinary care team
3. Care manager guides service delivery
4. Data is shared with PCP

Beneficiaries

1. LA Care Health Plan's Complex Care Managers
2. PCPs who care for complex patients under the LA Care Health Plan Dual Eligible line of business (CalMediConnect)
3. Dual eligible patients enrolled in the LA Care Health Plan Dual Eligible line of business (CalMediConnect)

Mission Budget/Cost

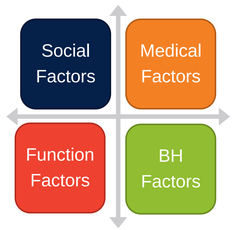
1. This project is designed to work within our current resource and budget structure
2. Via a process of continuous improvement we are constantly seeking to identify and replace inefficient workflows
3. This project is an example where we aim to replace an inefficient process with a new and improved method for complex case management

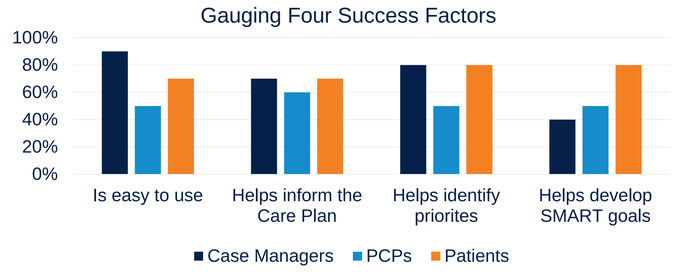
Mission Achievement/Impact Factors

1. The tool is demonstrably better in identifying patients ranking needs vs the alternative
2. The tool allows clear division of labor primarily in supporting the PCP-Patient encounter
3. The tool guides service delivery and upstream interventions before the need becomes a crisis
4. The earlier identification and resolution of ranking patient needs will lead to decreased ED and inpatient bed day use by 5% per quarter

Discovery

- Care Managers tested final draft tool with 100 patient
- Ranking needs tended to cluster into one of the four quadrants, often opposite the assumption, with greater visibility of the ranking need's impact to other categories
- Care Managers were able to systematically develop care plans with clear divisions of labor, particularly in supporting and maximizing the PCP- patient encounter
- Whereas coordinating medical care was easiest, coordinating Social Determinants was the hardest
- I interviewed 20 care managers, 10 patients and 10 PCPs to gauge impact of the tool in contrast to the usual assessment process





Lessons Learned

- Health professionals have different and varied levels of awareness regarding key factors driving health outcomes
- Care Managers, PCPs and patients each have a distinct, and different, model of problem sets and means toward resolution
- Health professionals accepted the concept only the tool fit their perception of the problem to be solved
- Most patients expressed satisfaction with Care Managers inquiring about social and Functional needs, but only if it was connected to a service that was helpful to them
- Care Managers had the greatest difficulty converting a Social need into a SMART goal, followed by Functional, Behavioral and Medical needs
- Understanding guidelines for medical care was a factor in successfully converting a need into a SMART goal, whereas the lack of standard guidelines, or not understanding guidelines, created barriers on other factors
- PCPs had the most difficulty in engaging because they did not clearly see the value of the approach to their practice

Next Steps

- Develop enhanced training modules for Care Managers
- Expand literature review to explore current best practice or toolkits available, particularly for Social and Functional Determinants
- Explore partnering with at least three high volume PCP practices to test tool across the spectrum
- Explore developing the Four Quadrant tool into an application
- Expand the timeline of the test to gauge longer term outcomes