Vermont Integrated Communities Care Management Learning Collaborative

Introduction

Identification of individuals who are at the highest risk for poor outcomes and who would benefit from care coordination interventions is vital. Use of risk stratification tools, claims, clinical and/or utilization data, screenings, assessments and chart reviews are helpful in identification of individuals who might be selected for care coordination activities. NCQA allows for provider and practice knowledge of their patient population to identify high risk patients. Things that might be considered are high in-office utilization of telephonic or other supports, people with limited or no family support, people with socioeconomic needs that might make them at higher risk.

It is recommended that you document the strategy that you select for identification of people with complex needs.

The following Clinical Risk Stratification Tool is one example utilizing Medicare, Medicaid and commercial payer methodologies for risk identification.

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Clinical Risk Stratification Tool

Identify

- Retrieve beneficiary detail report (BDR) from the OneCare Vermont portal for your tax ID practice/facility on a quarterly basis
- **Medicare and Medicaid**:will be filtered by Risk Rank Score 95-100
- **Commercial:** filtered by prospective severity score (6 - 1) review ≥ 5
- If the number of patients in this group is higher than resources could be allocated to in a three month time period, further risk stratify patients using additional criteria (suggestions below)

Stratify

- **Medicare (MSSP) , Medicaid (VMSSP) and Commercial**
- Filter by Risk Rank Score of 99-100 or 6 for commercial
- Filter by number of hospital admission**s** (Quick Tip: Look at the length of stays (LOS) and choose those patients who have the longest LOS
- Filter by comorbidities/chronic diseases (Quick Tip: Look at 3+ chronic conditions and go in increasing order to presence of all conditions
- Filter by number of ED visits (Quick Tip: Look at 3+ visits and go in increasing order to highest utilization)
- Filter by last PCP visit was > 1 year ago (Medicare and Medicaid)
- Filter by Medicare wellness visit of 0 (Medicare only)
- **Vermont Chronic Care Initiative (VCCI for Medicaid Only)**:
- Filter by those who have a 1 in the VCCI column (column DQ) - this means they are eligible for VCCI
- Then filter by "screening" or "new" in the status column, assit in referring to VCCI via "warm handoff" and evaluate for other needs

Apply

- Calculate number of patients who could benefit from care coordination
- Conduct care coordination activities , which may include the following:
- Conduct needs assessment of current care supports and gaps in care (example: chart review, care team/clinician consultation, patient interview)
- Conduct patient outreach activities (example: phone call, letter, referral & referral tracking, visit-based engagement, etc.)
- Track initial and follow-up care supports for selected patients using the BDR drop-down menu
- Upload the BDR within 90 days after receipt via secure portal