“EVERY DOCTOR HAS EXPERIENCED THE 80/20 RULE WHEN IT COMES TO TREATING THEIR SICKEST PATIENTS,” says Leonard Fromer, MD, FAAFP, Executive Director of Group Practice Forum and national expert on patient-centered medical homes (PCMH). “Essentially the smallest percentage of chronically ill patients use the majority of the practice’s time and resources with poorer results and higher costs.”

Policy makers and payers are hoping the cure for this malady is the PCMH and risk-stratified managed care (RSMC). By definition, it provides an appropriate level of support for each patient depending on the severity of their disease, which ultimately saves costs and keeps high risk patients from getting lost in the system.

“Risk stratification is a way out of the muck,” says Dr. Fromer. “It’s a very dynamic process that moves doctors, empowers care teams, integrates prevention, delivers right resource care and also predicts future risk. Physicians have spent 30 years rescuing chronic patients who come to them late in the disease process. Such changes require a major culture shift within medical practices.”
“Risk stratification must become a core competency for medical practices,” says Dr. Fromer. “When health professionals work together and involve patients, better outcomes are attained that cost less, create happier patients, and provide a higher level of satisfaction for provider teams.”

Re-engineering Practices

“PCMH and risk stratification make great sense as we are targeting individuals who are most in need of intervention and support,” says Kurt Elward, MD, MPH, of Family Medicine of Albemarle, a Virginia PCMH offering healthcare services in nine different specialties.

“Delivering population health management requires strategic oversight and the completion of many interdependencies,” says Dr. Elward. “We are evolving into a model of care with new processes, new technologies and new staff accountabilities. Strategies must be built on patient data to establish baseline, develop plans and measure progress.”

“Delivering population health management requires strategic oversight and the completion of many interdependencies”

Physicians need to lead this transition through their leadership and realignment of the care team. Here are tips from Dr. Fromer to get started:

- **REDEFINE** your healthcare team to include all professionals and resources, even the receptionist at the front desk.
- **LOOK** at your highest risk patients and pick a disease in which you think you can start to make a difference.
- **ALIGN** your team to engage high risk patients to better control their own disease.
- **ASSESS** your office workflow to promote better care delivery with higher patient satisfaction.
- **FOCUS** on team-based collaborative care and not silos.
- **PROMOTE** wellness and not damage control.
- **ENGAGE** patients in their own care.
- **MOVE** care plans beyond the practice into the community where patients live and work.
Building the Risk Pyramid

“Once you have compiled and evaluated your data, build a risk stratification pyramid and framework with your team. Evidence-based medicine (EBM) protocols should be a key part of your design,” says Dr. Elward. “Next, isolate data-driven items needed to identify those at risk, as well as meaningful interventions required for health improvement. Lastly, carefully design best levels of stratification by disease category and subgroups. This is the foundation for developing prioritized action plans and intervention strategies with your team.”

“Risk stratification has to be embedded in how you transform your practice,” says Dr. Elward. “First create a strategy within your practice and then within your larger health system. It’s to everyone’s benefit to work together to define measurement and resources that can help patients.”

“Stratification is the foundation for developing prioritized action plans and intervention strategies with your team”

MANAGING PATIENT DATA

- **START** with a thorough review of the patient database with your team.
- **IDENTIFY** highest risk and most challenging patients with potential for immediate improved outcomes.
- **EVALUATE** frequent hospitalizations, new onset diseases, past healthcare performance, demographics and prescription use.
- **INTEGRATE** data from electronic medical records (EMRs.)
- **COMPENSATE** for the EMR’s inability to support risk stratification and development of patient registries.
- **ALLOCATE** resources to implement compensatory manual processes.
DEVELOPING STRATEGIES AND ACTION PLANS

- CREATE dynamic registries that identify and follow patients now and over time.
- DEVELOP intervention plans for targeted patient outreach and engagement.
- DEPLOY appropriate resources to engage and empower patients.
- SET clear guidelines that identify care gaps requiring care coordination.
- TRAIN staff in specialty areas to support high risk patients, such as coaching and specialty clinics.
- MODIFY workflow to support new processes and procedures.
- ALIGN staff incentives based on risk reduction and good teamwork.

Delivering Risk-Stratified Care: Case Study

Sharon Messics, MD, is an internist and private practitioner affiliated with a PCMH in Maryland. “This PCMH model of care has immediate patient benefits and cost savings,” says Dr. Messics. “Consider the poor quality of life experienced by congestive heart failure (CHF) patients. Additionally, there are hefty penalties assigned to hospitals for CHF readmissions within 30 days. In our risk stratification model, CHF patients are flagged as red level (critical care) requiring a higher level of team intervention.”

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“Most patients don’t understand the advantages of a PCMH,” says Dr. Messics. “Health insurance and medical care only become important when needed; this is clearly part of the problem. Educating people about PCMH is an opportunity to educate patients on a new solution that does it better.”
MANAGING CHF: A COMMUNITY APPROACH

- Medical practice regularly checks in with CHF patients to educate, track and monitor health.
- Local pharmacists confirm patients’ medication understanding to improve compliance.
- Patients engaged through self-reported weight measurements that indicate water retention.
- Hospitals and emergency care clinics contact physician’s office following hospitalization for patient follow-up.
- Home health resources notified to provide a home visit post-hospital discharge.
- Physician staff members educated on working with CHF patients who may be older and overwhelmed by information.
- EMR tracks and records encounters, visible to key providers.
- Care team works together to create a better patient experience, and ultimately, outcome.
LEONARD FROMER, MD, FAAFP
As Executive Medical Director of the Group Practice Forum, Dr. Fromer leads a team engaged in national projects with group practices that deliver education, tools, and services to achieve success in their clinical integration efforts. Dr. Fromer lectures extensively on the topics of health-system reform, the patient-centered medical home and the accountable care organization. He has been featured on CBS News, ABC News, and in the New York Times.

KURT ELWARD, MD, MPH
Dr. Elward leads Family Medicine of Albemarle, a patient-centered medical home which offers health care services in nine different specialties. Through his role as Medical Director of the Medical Society of Virginia Foundation’s (MSVF) Quality Improvement Program, Dr. Elward leads a physician-driven approach to clinical care quality improvement. Dr. Elward developed “TOGOAL-COPD”, an initiative of the MSVF that combines recertification activities with state of the art performance enhancement to achieve improvements in measures of excellence in chronic care, and support primary care practices’ development of foundational elements of the Patient Centered Medical Home.

SHARON MESSICS, MD
Dr. Messics works as single practitioner in a Patient-Centered Medical Home fostering “a rewarding, trusting partnership between a doctor-led healthcare team and an informed patient.” Under Dr. Messics’ leadership, her practice earned medical home NCQA Level 3 recognition in 2012.

For more tips on using the patient-centered medical home model in your practice, subscribe to our content at www.bestdoctors.com/Subscribe.
Additional PCMH resources can be found at www.bestdoctors.com/PCMH.

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