How to make Risk Adjustment Less of a Pain!

Presented By:

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3M Health Information Systems

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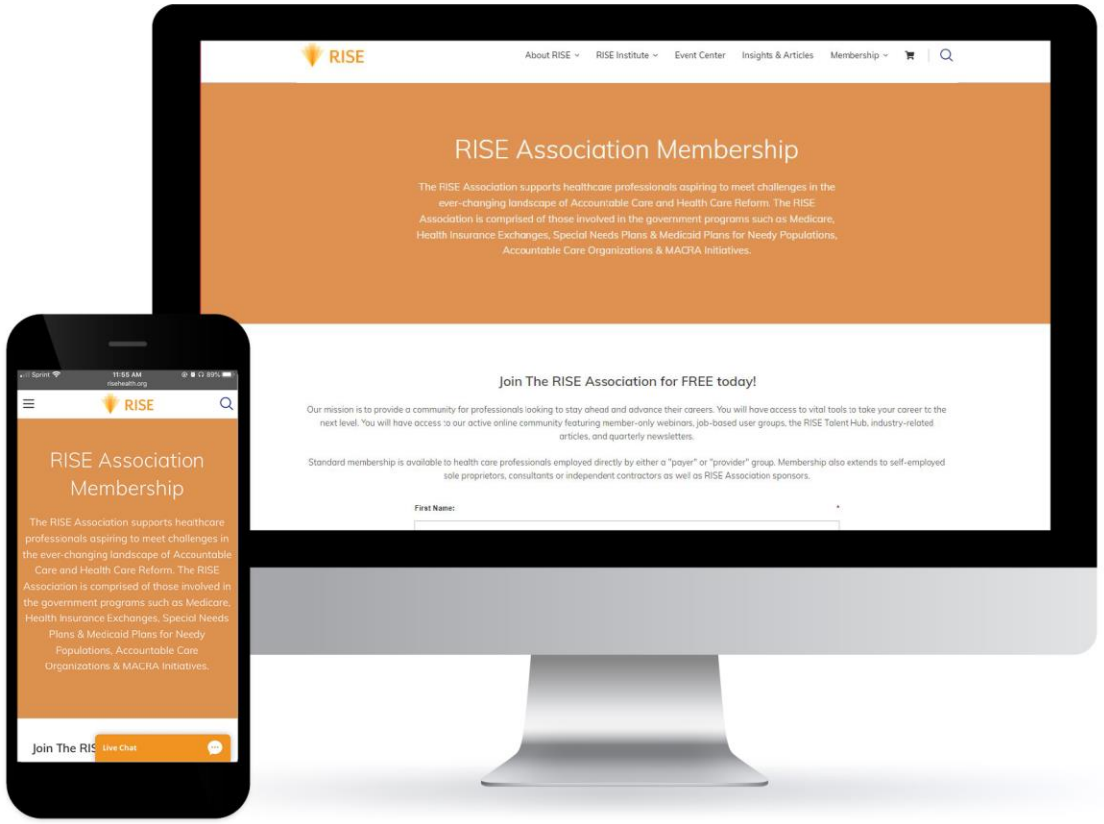

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Summary

Value-based purchasing hinges on risk adjustment – payment is adjusted based on the illness burden of patients. Complete and accurate clinical documentation is essential but requires additional work of clinicians. We will discuss how to bridge the need for low-burden workflow with requirements for documentation and quality, and how technology and data may enable or get in the way. Join Dr. Gordon Moore 3M HIS as he discusses the impact of risk adjustment models and the importance of health care organizations preparing now for future success.

Agenda

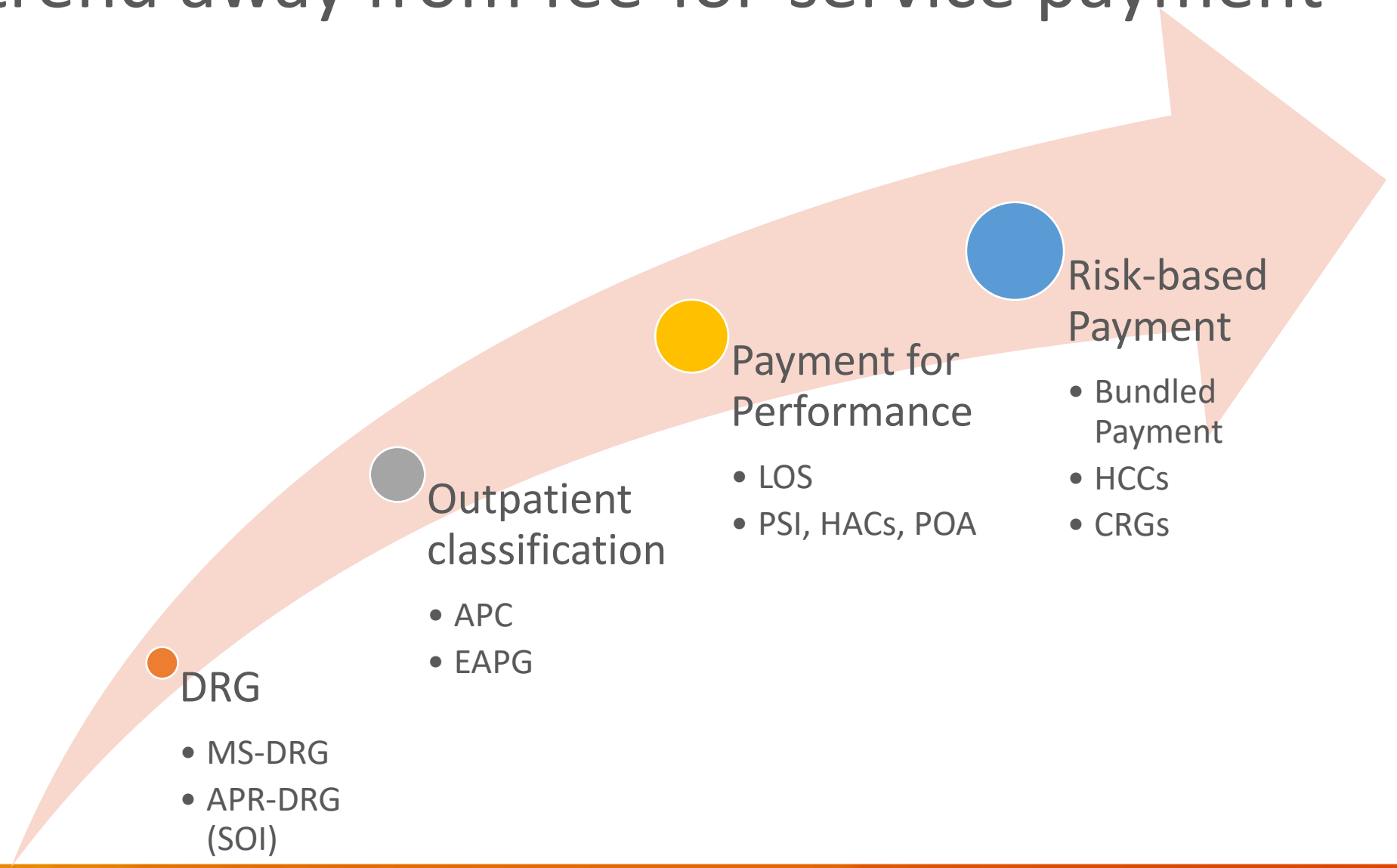
Risk-based patient population; the continued shift from fee for service

Leveraging quality, data and technology as part of the process

Creating a process now will set the future success

Key considerations when creating your goals

The trend away from fee-for-service payment



Why risk adjustment?

Base Condition(s) and Diagnosis codes	3M CRG assignment	CRG Weight *Child*	PMPM	IP Visits PKPY	ER Visits PKPY
Opioid Dependence *F11.20 Opioid dependence, unspecified*	CRG 57831 Opioid Abuse/Dependence Level - 1	**1.732**	**$ 393.92**	**90**	**1,433**
Opioid Dependence + Overdose *F11.20 Opioid dependence, unspecified* *T507X1A Poisoning by analeptics and opioid receptor antagonists, accidental (unintentional), initial encounter*	CRG 57832 Opioid Abuse/Dependence Level - 2	**2.811**	**$ 437.12**	**260**	**1,247**
Opioid dependence + Overdose + Schizophrenia *F11.20 Opioid dependence, unspecified* *T507X1A Poisoning by analeptics and opioid receptor antagonists, accidental (unintentional), initial encounter* *F20.9 Schizophrenia, unspecified*	CRG 61213 Dominant Chronic Mental Health Disease and Other Dominant Chronic Substance Abuse Level - 3	**9.676**	**$ 1,092.61**	**903**	**1,518**

Source: Sample State Medicaid Managed Care plan data CRG v2.1

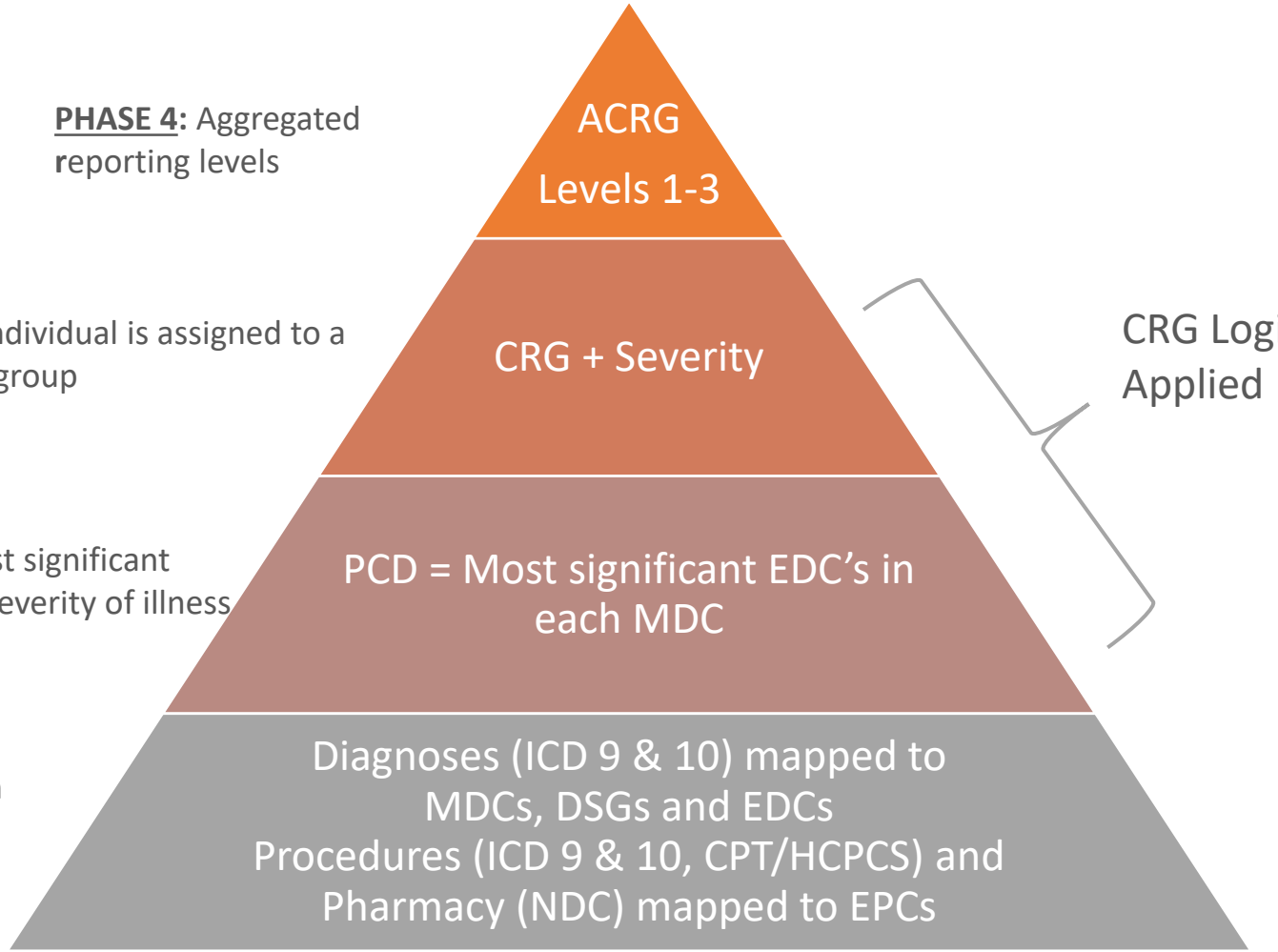
How risk adjustment works:
Overview of 3M CRG assignment in four phases

PHASE 4: Aggregated reporting levels

PHASE 3 : Individual is assigned to a clinical risk group

PHASE 2 : Identifies most significant conditions and assigns severity of illness

PHASE 1 : Input data provided on claims, builds medical profile



Using risk adjustment to measure performance

Provider Groups/ PPS/Region	Members	Member Months	CRG Weight	Total Paid PMPM $	Total Expected Paid PMPM $	Total %Diff.
Provider 1	66,322	708,580	1.204	$483.31	$457.73	5.6%
Provider 2	12,139	130,494	1.285	$477.08	$489.87	-2.6%
Provider 3	17,040	182,377	0.817	$315.43	$297.60	6.0%
Provider 4	4,297	45,719	1.139	$477.18	$424.24	12.5%
Provider 5	43,832	472,835	1.270	$483.70	$481.63	0.4%
Provider 6	19,916	211,067	1.546	$607.64	$599.99	1.3%
Provider 7	121	1,328	2.202	$667.45	$813.87	-18.0%
Provider 8	278,236	2,458,729	0.689	$239.66	$261.82	-8.5%
Provider 9	4,535	47,959	1.516	$634.48	$562.56	12.8%
Provider 10	14,398	154,927	1.245	$474.01	$466.27	1.7%
Provider 11	176,414	1,896,994	1.160	$449.68	$436.20	3.1%
Aggregate	**637,250**	**6,311,009**	**1.000**	**$378.48**	**$378.48**	**0.0%**

Apples to apples *performance comparison because this metric measure the distance from the expected value*

Using risk adjustment for care management

Each cell represents the number of people with diabetes for each segment of health status and severity (out of a population of 250,000)

	Severity Level					
Status (Case Mix Type)	1	2	3	4	5	6
1 Healthy						
2 One or More Significant Acute Disease						
3 One Minor Chronic Disease						
4 Multiple Minor Chronic Diseases						
5 One Significant Chronic Disease	2,290	665	227		57	
6 Two Significant Chronic Diseases	3,718	1,430	963	631	239	29
7 Three of More Significant Chronic Diseases	372	285	378	96	79	35
8 Complicated Malignancies	1	40	68	52	19	
9 Catastrophic Conditions	3	23	9	17	17	9

Figure 1. View of diabetes distributed within a CRG (Version 1.2) case mix and severity matrix for a representative commercially insured population of 250,000 people.

Bernstein, Richard H. "New Arrows in the Quiver for Targeting Care Management: High-Risk versus High-Opportunity Case Identification." *The Journal of Ambulatory Care Management* 30, no. 1 (March 2007): 39–51

Total burden of illness (3M CRG) average: Diabetes

The total burden of illness varies immensely across a population of people with diabetes

	Severity Level					
Status (Case Mix Type)	1	2	3	4	5	6
1 Healthy						
2 One or More Significant Acute Disease						
3 One Minor Chronic Disease						
4 Multiple Minor Chronic Diseases						
5 One Significant Chronic Disease	0.98	1.38	2.21		2.42	
6 Two Significant Chronic Diseases	1.84	3.14	4.07	4.41	7.06	20.41
7 Three of More Significant Chronic Diseases	2.77	4.38	11.48	14.89	18.19	37.43
8 Complicated Malignancies	1.16*	11.64	17.74	34.09	37.20	
9 Catastrophic Conditions	3.21*	9.00	17.95	25.89	22.82	46.81

Figure 2. Burden of illness (BOI) scores of individuals with diabetes for a representative commercially insured population. The small number of individuals in these categories creates a BOI score that may not be representative.

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Hospitalizations per 1,000 people per year: Diabetes

Illness status and severity enables focused intervention

	Severity Level					
Status (Case Mix Type)	1	2	3	4	5	6
1 Healthy						
2 One or More Significant Acute Disease						
3 One Minor Chronic Disease						
4 Multiple Minor Chronic Diseases						
5 One Significant Chronic Disease	26	88	100		247	
6 Two Significant Chronic Diseases	43	119	195	320	644	1,023
7 Three of More Significant Chronic Diseases	132	269	497	845	1,343	1,606
8 Complicated Malignancies	416*	209	493	1,294	2,242	
9 Catastrophic Conditions	290*	626	806	990	1,685	2,686

Figure 3. Admissions per 1,000 individuals with diabetes for a representative commercial population. The small number of individuals in these categories creates admissions per 1,000 rates that may not be representative.

Bernstein, Richard H. "New Arrows in the Quiver for Targeting Care Management: High-Risk versus High-Opportunity Case Identification." *The Journal of Ambulatory Care Management* 30, no. 1 (March 2007): 39–51

It all starts with clear and precise documentation

RESEARCH ARTICLE THE PRACTICE OF MEDICINE

HEALTH AFFAIRS > VOL. 38, NO. 7: PHYSICIANS, NURSES, DISPARITIES & MORE

Physicians' Well-Being Linked To In-Basket Messages Generated By Algorithms In Electronic Health Records

Ming Tai-Seale, Ellis C. Dillon, Yan Yang, Robert Nordgren, Ruth L. Steinberg, ... See all authors

AFFILIATIONS

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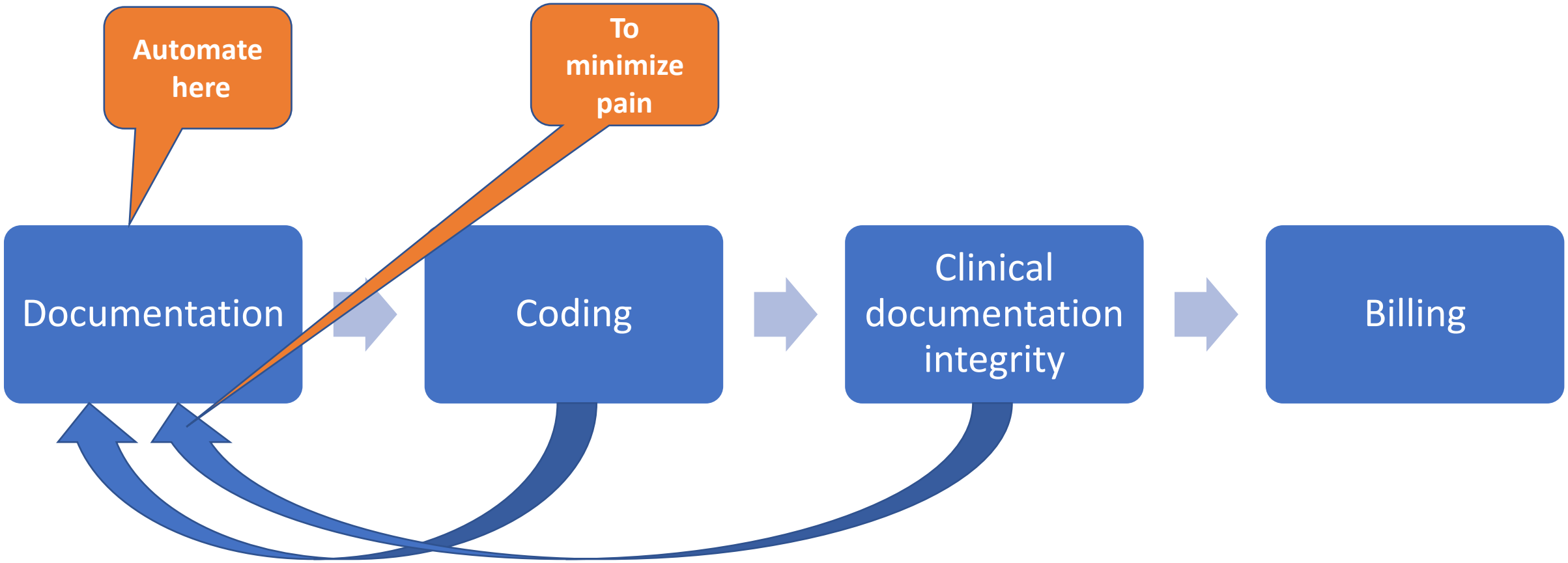
SECTIONS VIEW ARTICLE PERMISSIONS SHARE TOOLS

ABSTRACT

Despite concerns about physicians' workload associated with electronic health records (EHRs), little attention has been paid to the relationship between physicians' well-being and the in-basket messages physicians receive—specifically, their volume and sources. Analyses of EHR work performed by physicians in a multispecialty practice found that in-basket messages

Receiving more than the average number of system-generated in-basket messages was associated with **40 percent higher probability of burnout**

Reduce friction with artificial intelligence and combined workflow



3M | mModal

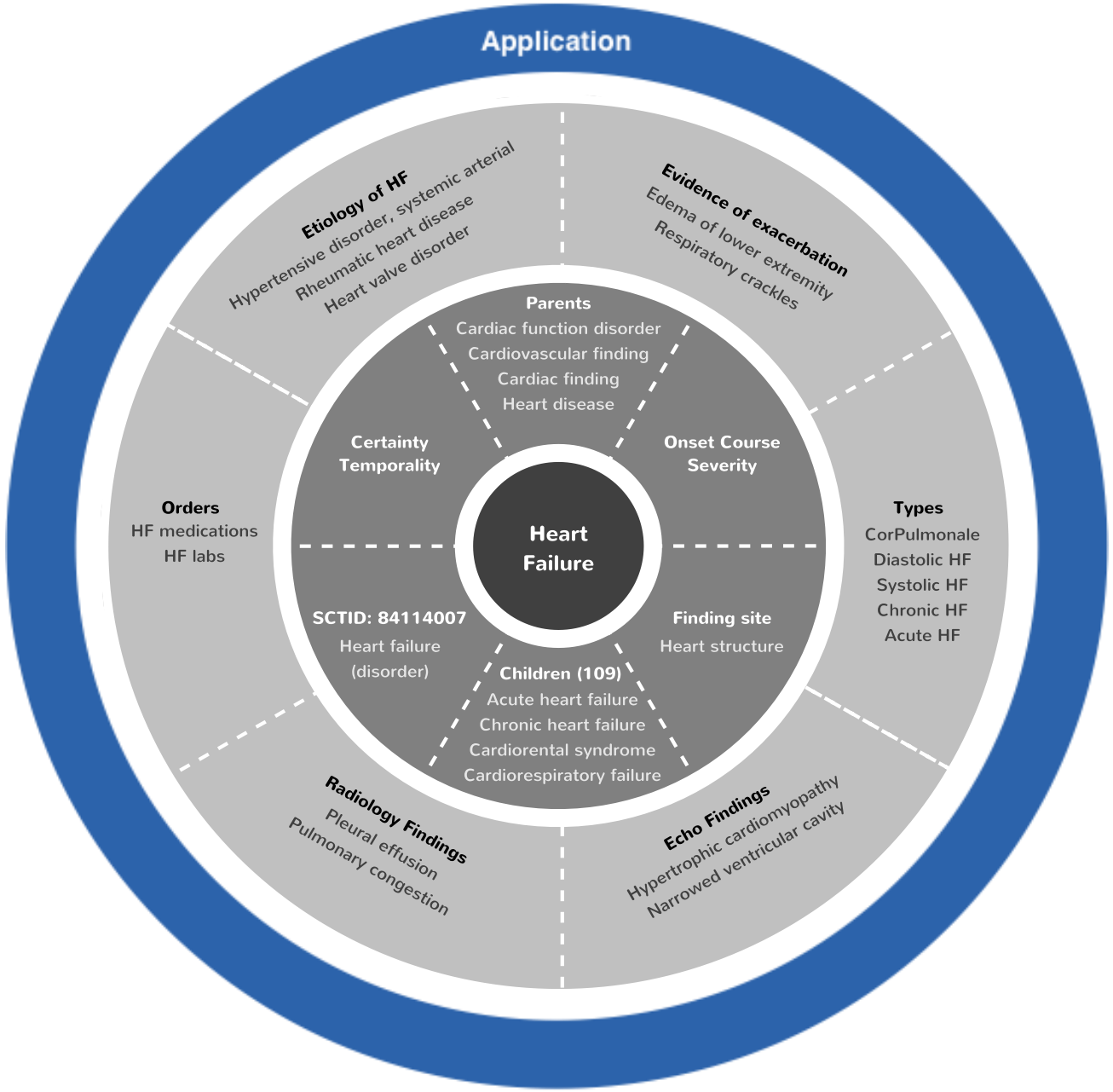
Catalyst

Aggregates and reasons over clinical information from various sources, such as narrative documents and discrete data.

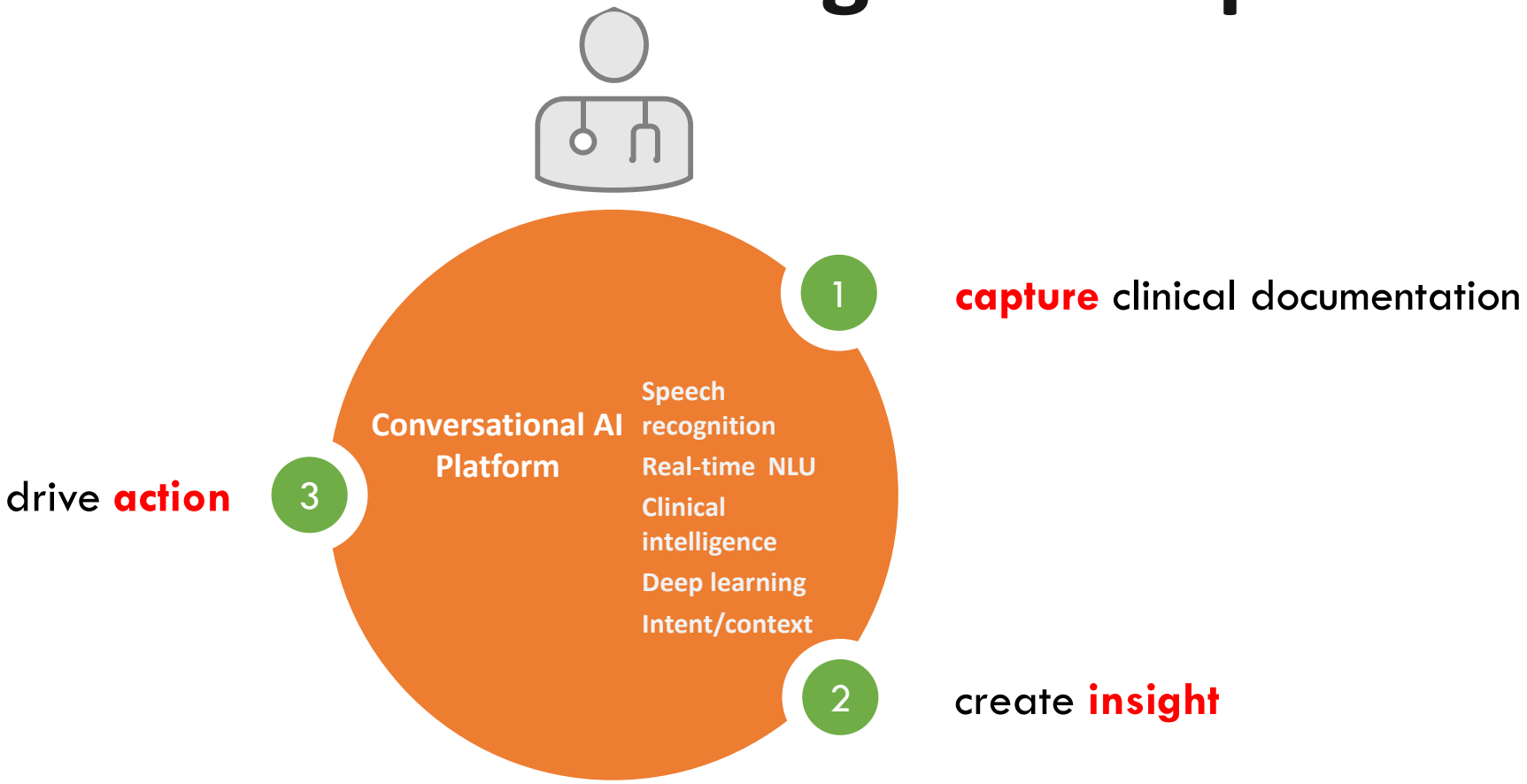
Relies on standard ontologies, such as SNOMED, to establish relationships between medical terms.

Establishes clinical value sets for related treatment, findings, procedures, manifestations, etc.

Uses a combination of **artificial intelligence**, **machine learning** and **rules engines**.



Conversational AI: Closing the Loop



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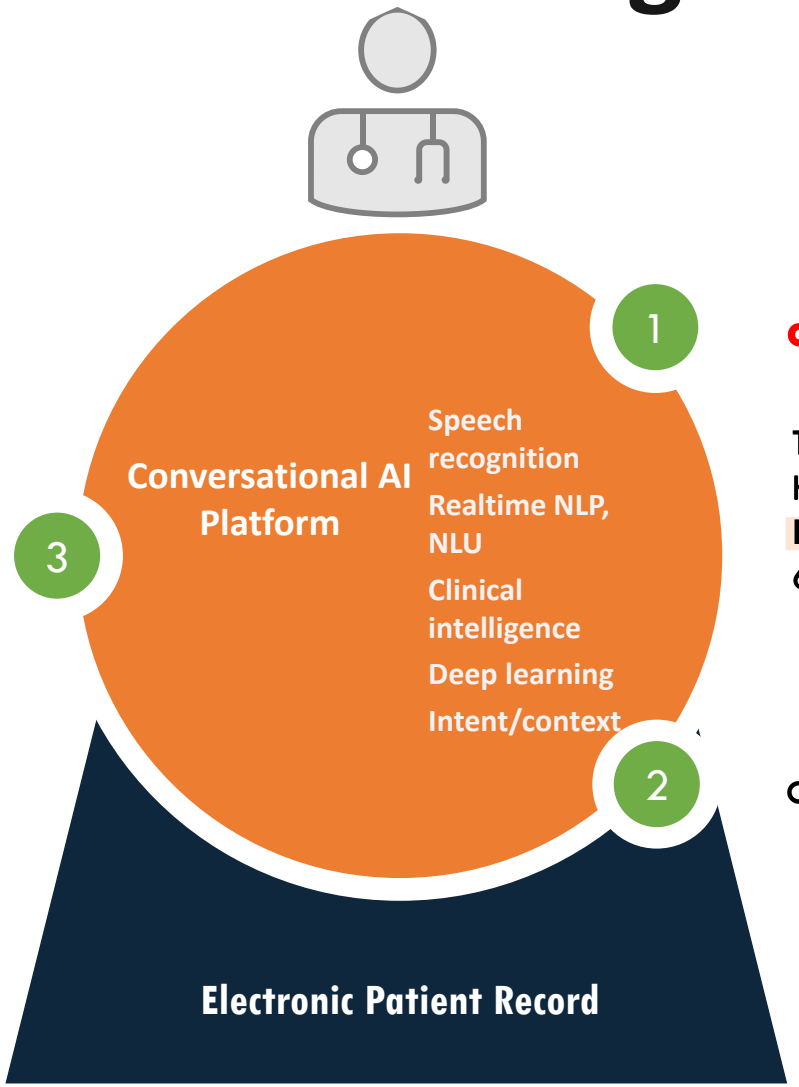


capture clinical documentation

The patient has **acute systolic congestive heart failure.** His history is significant for type 2 diabetes mellitus and **hypertension.** His current medications include Coumadin 6 mg once daily and **lisinopril 10 mg twice daily.**

drive **action**

Heart failure

Please consider specifying the **acuity** and **type**

- acute diastolic
- acute systolic
- chronic diastolic

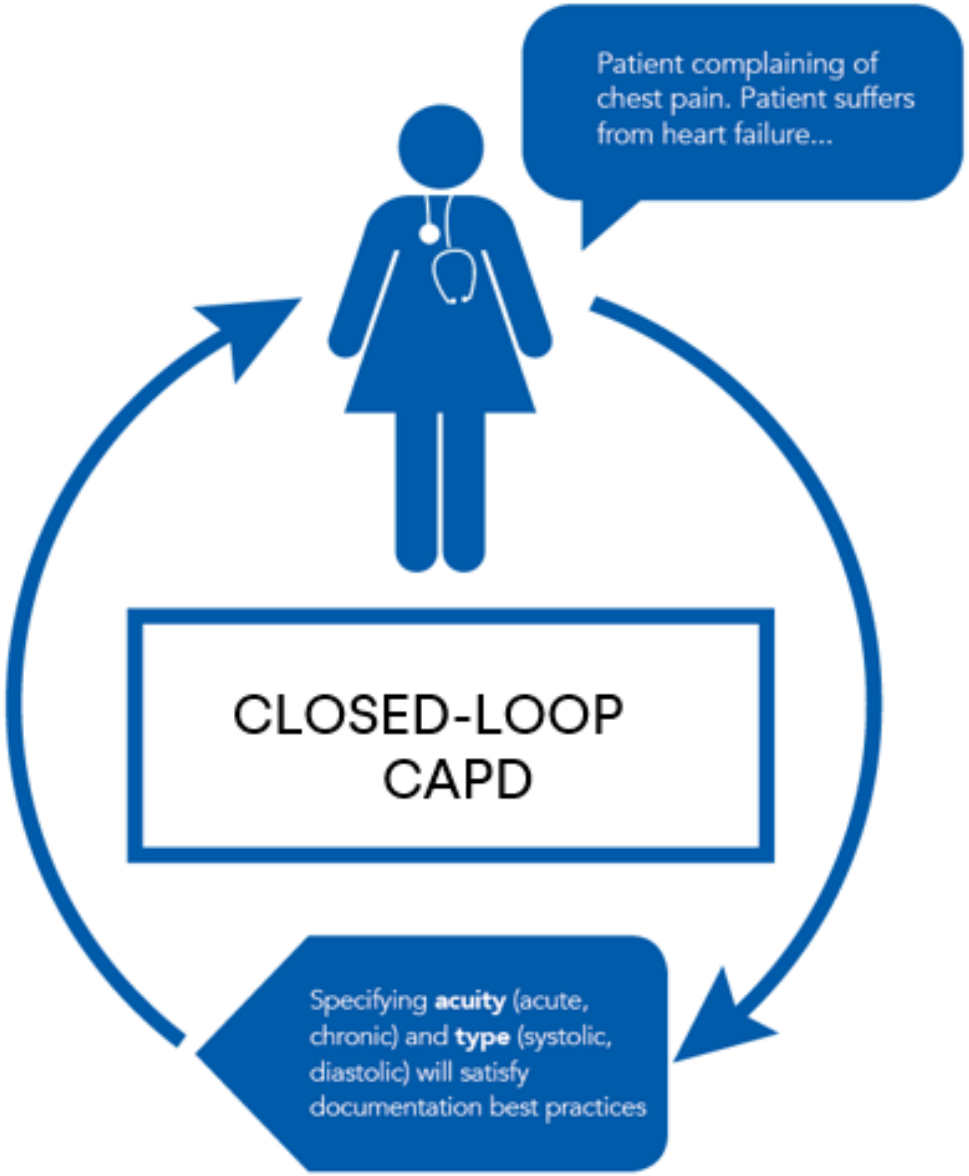
create **insight**

Structured and encoded CDA documents

Engaging the Clinician at the Golden Moment

Creating time to care with proactive physician engagement

- Real-time, in-workflow nudges
- Continuous analysis and monitoring of clinical narrative across the patient encounter
- Efficient creation of higher-quality documentation
- Transform the EHR documentation experience

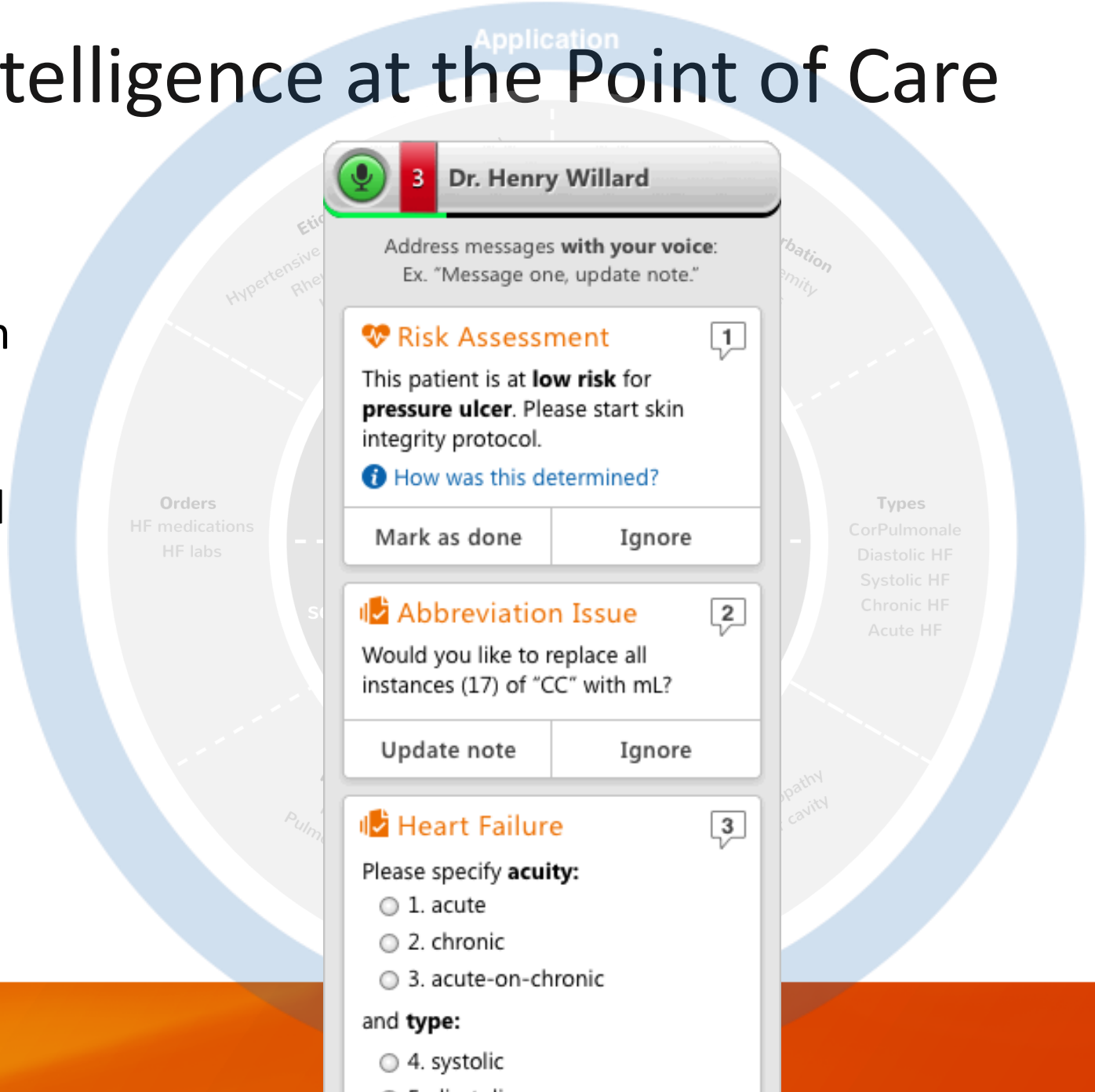


Real-Time Clinical Intelligence at the Point of Care

Computer Assisted Physician Documentation (CAPD)

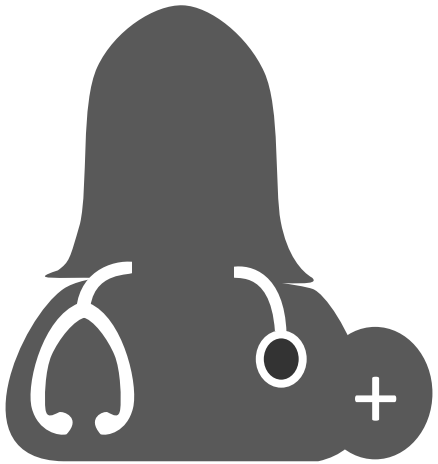
- Clinical understanding platform delivers real time feedback
- Encourages consistency, objectivity and evidence-based medicine, closes care gaps, improve communication - proactively

CDI Engage One



How to Avoid a Retrospective Query

- Bring education out of the classroom and into the physician documentation workflow
- Improve the quality of documentation at the time of note creation
- Promote an information-driven, consistent and reliable approach to physician documentation
- Facilitate CDI review of high-value cases with advanced prioritization
- Extend CDI programs and coverage through streamlined workflows



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