Addressing the Needs of Your
Rising-Risk Patients

Executive Summary

Look Inside For

- The case for rising-risk management
- High-level steps to develop a sustainable rising-risk strategy
- References to detailed resources covering all stages rising-risk management

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Rising-Risk Patients, an "Invisible" But Large Population

For every provider engaged in risk-based contracts, effective care management of high-risk patients is a universal starting point. For progressive organizations, surfacing the needs of rising-risk patients for targeted improvement is the logical next step, but one that's easier said than done.

Rising-risk patient management is difficult because it's hard to develop a strategy around an unknown, yet sizable population.

Patient Risk Escalation

High-Risk Patients

Rising-Risk Patients

Low-Risk Patients

15%-35%
of your patient population is rising risk

Key Characteristics of Rising-Risk Patients

1 Patient has 1 to 2 well-managed chronic diseases

2 Symptoms not severe and can be ignored

3 Patient has co-occurring psychosocial risk factors
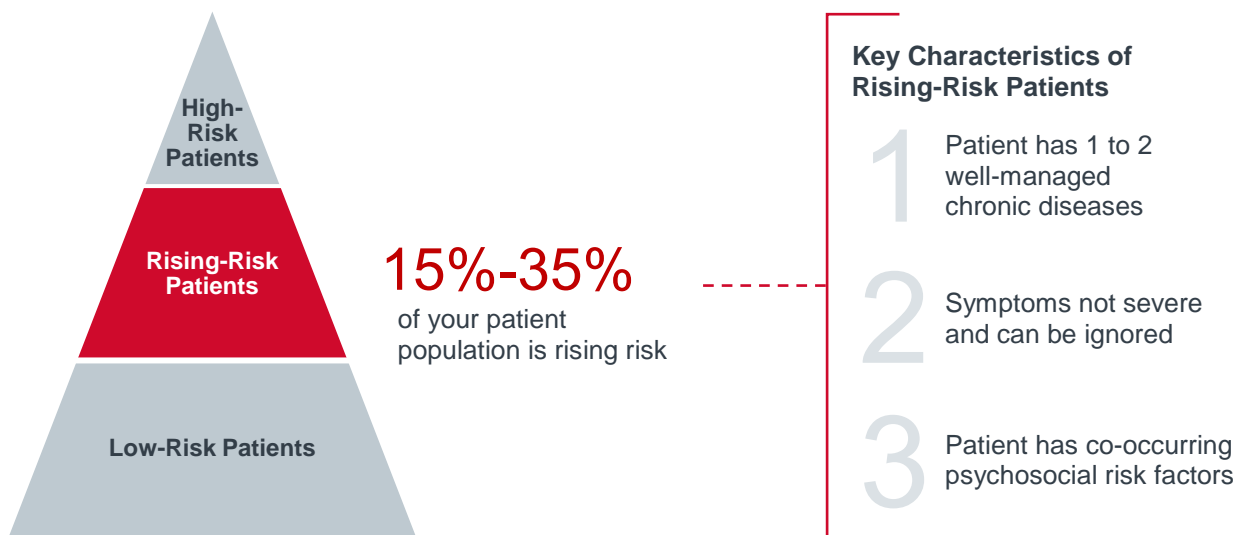
Rising-risk patients are hard to identify because their symptoms can be minimal, which is why they don't always interact with primary care. And even when they do, these patients are more likely to have isolated touchpoints with a diverse group of providers (e.g., urgent care, specialists), rather than repeated appointments with the same doctor.

Identifying these patients is not the only problem. For many providers resources are constrained, making it difficult to justify dedicating resources aimed at rising-risk management. Instead, resources are centered on high-risk patient management given the clear business case that high-risk patients account for a significant, disproportionate share of medical costs.

Rising-Risk Patients, a Chance to Bend the Cost Curve

However, leaders must remain aware that rising-risk patient management is a cost avoidance strategy. Given the size of the population, it can represent a health systems' greatest opportunity for demand management.

Cost Growth of High-Risk Patients with and without Rising-Risk Management[1]

Cost saving opportunity: Leading population health managers have reduced rising-risk escalation rates by one-third via their care management efforts

Resources

Time

— No rising-risk management

— Effective rising-risk management
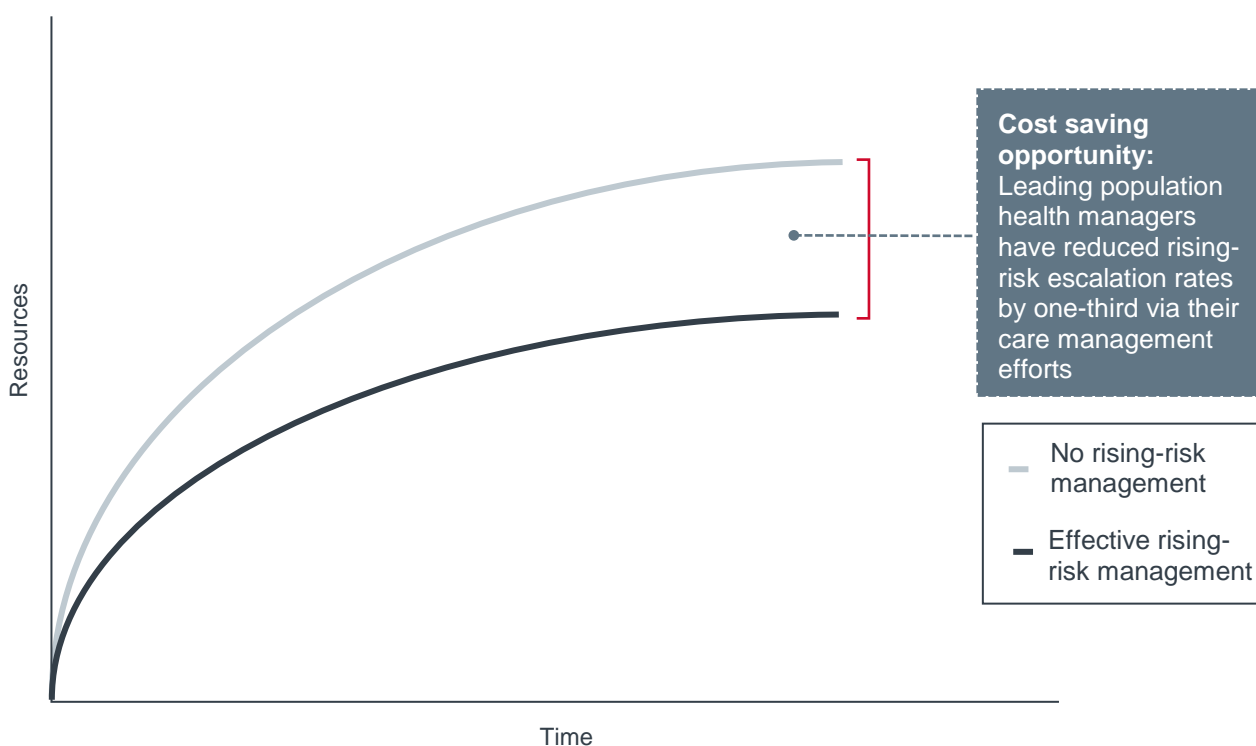
1) Lines are representative of high-risk cost growth over time. The light grey line is high-risk cost growth without reducing rising-risk escalation. The darker grey line represents a reduction in high-risk cost due to decreased escalation.

Each year, about 18% of rising-risk patients escalate into the high-risk category when not managed. By investing in rising-risk patient management, organizations can significantly slow the churn of rising-risk patients into the high-risk patient cohort and avoid associated future costs.

To explore the business case for rising-risk patient management in more depth, Population Health Advisor members can review advisory.com/businesscase

Narrow Focus through Shared Triggers and Risk Factors

Leading organizations largely target strategic resources at the intersection between primary care and chronic disease management to curb cost and demand. To do so, they prioritize across rising-risk management efforts based on key patient risk factors.

There are two main triggers to a rising-risk patient's escalation: unpredicted exacerbation and uncontrolled disease progression. The most common risk factors that drive escalation include clinical conditions going undiagnosed, a lack of patient understanding of or motivation for self-management, and inadequate patient access to providers or supportive services. Directing resources to solve these barriers can narrow the focus of the patient management strategy.

Common Triggers of Rising-Risk Patient Escalation

Precipitating Crisis	Unpredicted exacerbation befalls patient; unable to recover, patient escalates to high risk	→	**Opportunity for inflection**
Uncontrolled Disease Progression	Patient unaware of condition or ignores condition management; lack of behavior modification speeds escalation	→	**Opportunity for inflection**
Controlled Disease Progression	Patient manages condition according to plan; over time underlying condition deteriorates for natural reasons	→	**Ideally treated with care management or end-of-life care**

Short Term ———————————————————————→ **Long Term**

Since these triggers can (and do) happen in tandem, organizations cannot afford to take a piecemeal approach to their rising-risk management strategy and instead must focus on the patient holistically.

A holistic approach starts with identifying which patients are at risk, why they are at risk, and then prioritizing patients that are willing and will most likely benefit from planned interventions.

To effectively interrupt the escalation from rising- to high-risk, population health managers uncover core drivers—often clinical and non-clinical in nature—behind patient risk. They consider chronic condition diagnoses, biopsychosocial risk factors, and patient levels of health literacy and engagement to determine which interventions are most appropriate.

To explore common non-clinical risk factors and how to address them in more depth, Population Health Advisor members can review advisory.com/non-clinicalrisk

Developing a Sustainable Rising-Risk Strategy

Unsure where to start? A sustainable rising-risk management program requires a two-step approach, incorporating the four lessons below:

1

Identify Your At-Risk Populations

Identify your at-risk target population by focusing on key risk factors and triggers.

2

Engage Partners to Maximize Scale

Promote sustainable change by engaging primary care, patients, caretakers, and the community to meet patients' holistic needs.
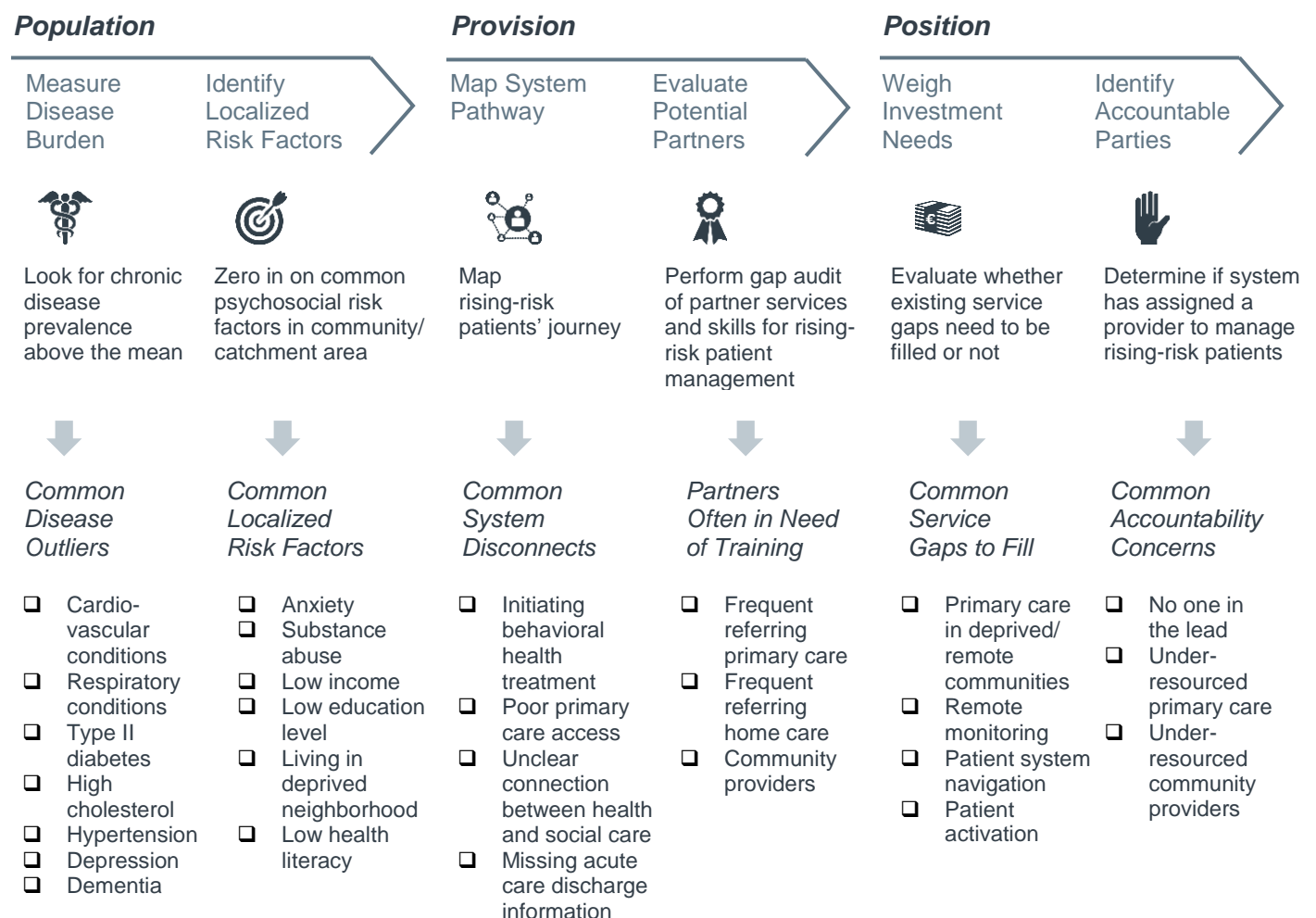
1. Refresh your strategy to identify at-risk patients every one-to-two years, focusing on key risk factors and escalation triggers.
2. Use the medical home as the epicenter of patient management.
3. Focus patient education on building self-management skills.
4. Engage community organizations to fill care gaps surfaced in the community health needs assessment.

Refresh At-Risk Patient Identification Strategy Biannually

In order to run targeted rising-risk interventions, population health leaders start with data analytics to identify their at-risk patient population, then build a system around these patients.

While ideal starting points, commonly used data sources (e.g., internal clinical data, billing history, and demographic information) are often insufficient because they fail to show a comprehensive picture of the rising-risk patient population. Population health leaders start out by filling gaps in internal system datasets with additional data on activation, social needs, and other risk factors from partnering institutions. An enhanced dataset can provide a more accurate view of who these patients are and how to address their needs. Organizations with a more refined strategy recognize that going through the process of surfacing gaps, informing their risk stratification strategy, and identifying at-risk patients is a continually evolving process.

Pathway for Creating a Rising-Risk Action Plan

Population

Measure Disease Burden	*Identify Localized Risk Factors*

Look for chronic disease prevalence above the mean

Zero in on common psychosocial risk factors in community/ catchment area

Common Disease Outliers

- ❑ Cardio-vascular conditions
- ❑ Respiratory conditions
- ❑ Type II diabetes
- ❑ High cholesterol
- ❑ Hypertension
- ❑ Depression
- ❑ Dementia

Common Localized Risk Factors

- ❑ Anxiety
- ❑ Substance abuse
- ❑ Low income
- ❑ Low education level
- ❑ Living in deprived neighborhood
- ❑ Low health literacy

Provision

Map System Pathway	*Evaluate Potential Partners*

Map rising-risk patients' journey

Perform gap audit of partner services and skills for rising-risk patient management

Common System Disconnects

- ❑ Initiating behavioral health treatment
- ❑ Poor primary care access
- ❑ Unclear connection between health and social care
- ❑ Missing acute care discharge information

Partners Often in Need of Training

- ❑ Frequent referring primary care
- ❑ Frequent referring home care
- ❑ Community providers

Position

Weigh Investment Needs	*Identify Accountable Parties*

Evaluate whether existing service gaps need to be filled or not

Determine if system has assigned a provider to manage rising-risk patients

Common Service Gaps to Fill

- ❑ Primary care in deprived/ remote communities
- ❑ Remote monitoring
- ❑ Patient system navigation
- ❑ Patient activation

Common Accountability Concerns

- ❑ No one in the lead
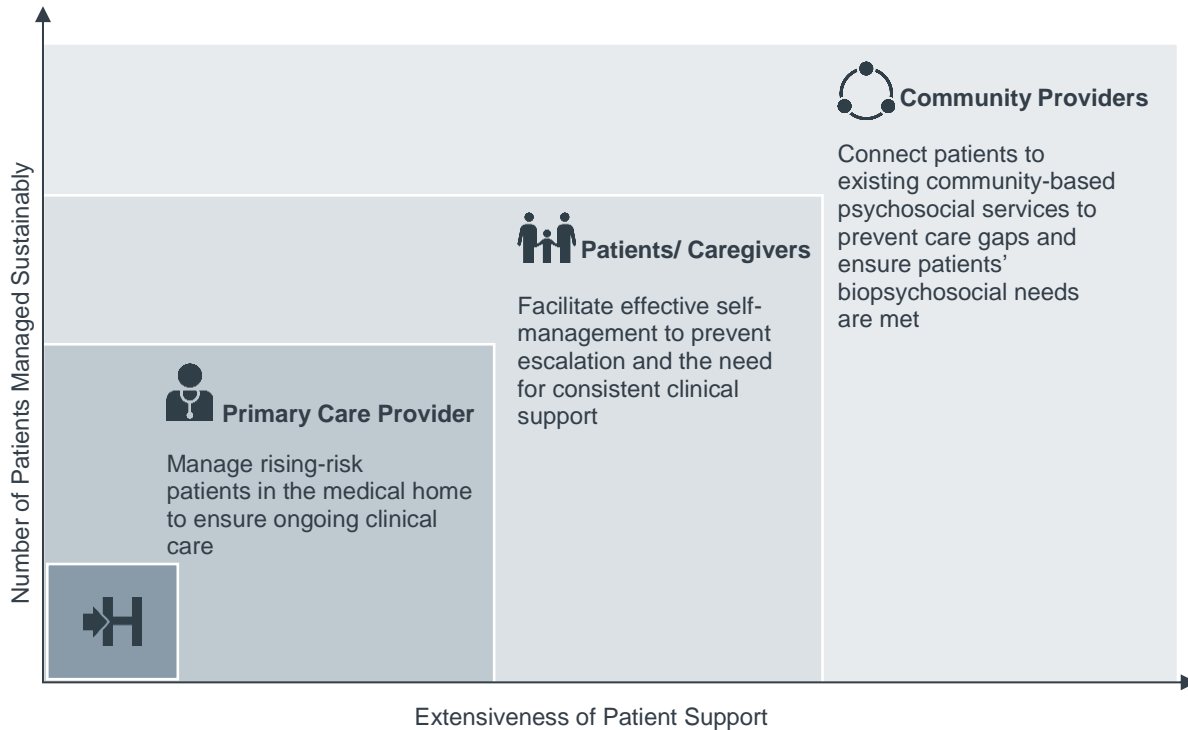- ❑ Under-resourced primary care
- ❑ Under-resourced community providers

To explore how to identify your at-risk population in more depth, Population Health Advisor members can review advisory.com/mindthegap

advisory.com

Engage Your Cross-Continuum Partners to Achieve Scale

Once rising-risk patients are identified, population health managers must work with partners wherever possible—from primary care practices to community-based ancillary and non-clinical providers—to achieve scale and meet the demands of the large rising-risk patient group. Effective scaling involves the three-pronged partnership strategy outlined below.

Engage Partners to Achieve Scale

Number of Patients Managed Sustainably (y-axis)

Extensiveness of Patient Support (x-axis)

Primary Care Provider

Manage rising-risk patients in the medical home to ensure ongoing clinical care

Patients/ Caregivers

Facilitate effective self-management to prevent escalation and the need for consistent clinical support

Community Providers

Connect patients to existing community-based psychosocial services to prevent care gaps and ensure patients' biopsychosocial needs are met

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To explore scaling rising-risk patient management in more depth, Population Health Advisor members can review advisory.com/scaling
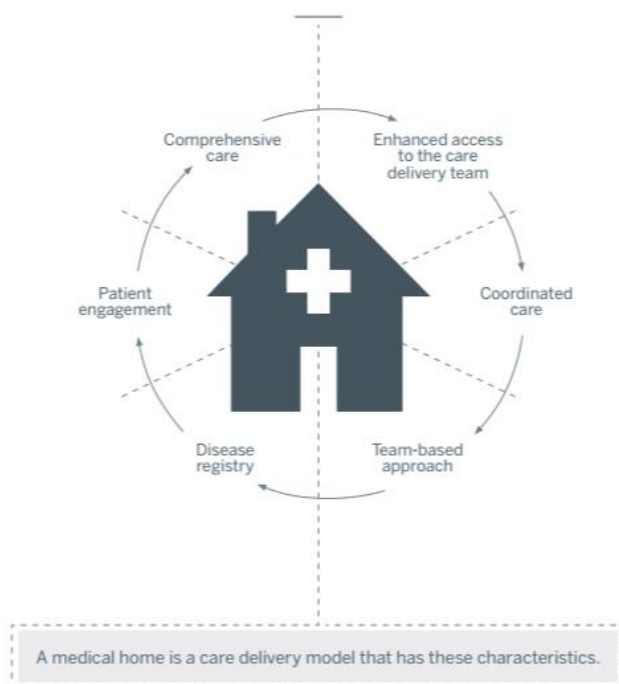
advisory.com

Use Medical Home as Epicenter of Patient Management

The sheer number of rising-risk patients will require organizations to develop lean and flexible interventions that build on the primary care team at its core.

Population health leaders prioritize the enrollment of rising-risk patients within the medical home, where team-based approaches to care provide the right balance between customization and scale.

Six Principles Define Medical Home Concept

Comprehensive care

Enhanced access to the care delivery team

Patient engagement

Coordinated care

Disease registry

Team-based approach

A medical home is a care delivery model that has these characteristics.

To maximize the impact of the medical home, population health leaders focus their efforts on:

1. Shared care needs across the population (e.g., behavioral health needs, medication reconciliation)
2. Engagement of patient influencers, such as family and friends
3. Care transition support

To explore medical home best practices in more depth, Population Health Advisor members can review advisory.com/advancedmedicalhome
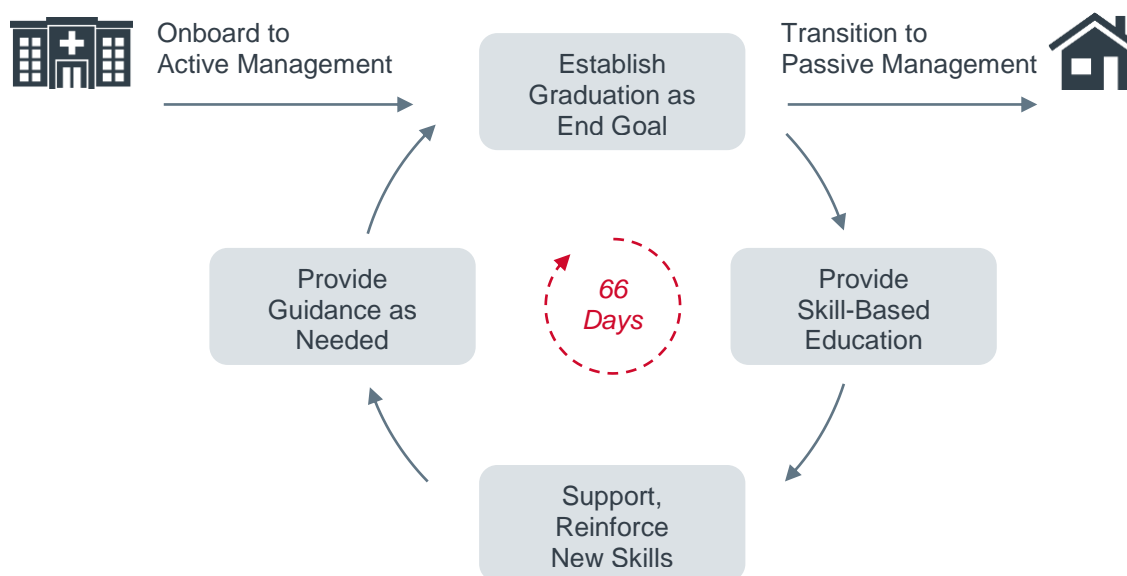
Focus Patient Education on Self-Management Skills

Effective patient self-management in-between primary care appointments reduces the risk of escalation and can inflect avoidable acute care utilization.

The care team plays a critical role in kicking off effective, long-term self-management.

Key Steps for Care Team

The goal of patient engagement is to facilitate patient self-management. Hardwiring engagement strategies into provider workflow and ensuring scalability of services for the large rising-risk population are key. There are eleven main strategies to do so:

1. Develop short-term active patient engagement strategies to equip patients for long-term self-management.
2. The primary care team plays a limited, but critical, role in patient engagement.
3. Ensure the team has an accurate picture of a patient's care needs, especially behavioral health conditions.
4. Use personal goals, not just clinical goals, to fuel patients' long-term motivation.
5. Create a strong link between primary care and next steps by proactively scheduling follow-up.
6. Build a flexible system focused on when patients are ready to engage.
7. Graduation is the key to scaling patient engagement strategies across the entire population.
8. Focus education on building the skills necessary to integrate chronic condition management into day-to-day routines.
9. Boost engagement with targeted support from the expanded care team.
10. Step down care management support to start the transition to self-management.
11. Graduation signals the end of active management, but not the end of your patient engagement strategy. Ongoing management should support patients and reinforce the patient-care team link.

To explore patient engagement in more depth, Population Health Advisor members can review advisory.com/patientengagement

Use Community Partners to Fill Non-clinical Care Gaps

Partnerships among health systems, public health bodies, and community organizations are the most effective ways to sustainably address patients' social risk factors.

Most organizations are traveling on separate but parallel paths toward building healthier communities, which typically leads to valuable data, information, and resources being siloed. There are four ways to set up successful community partnerships:

1. Build a compelling business case to garner executive buy-in and needed resources
2. Determine what services or programs to start with, recognizing that the process will be iterative
3. Leverage unique strengths of community organizations to extend care team reach
4. Clearly link seamless screening and referral protocols to ensure timely follow-through and improved patient and provider satisfaction

Sphere of Patient Activity and Interactions
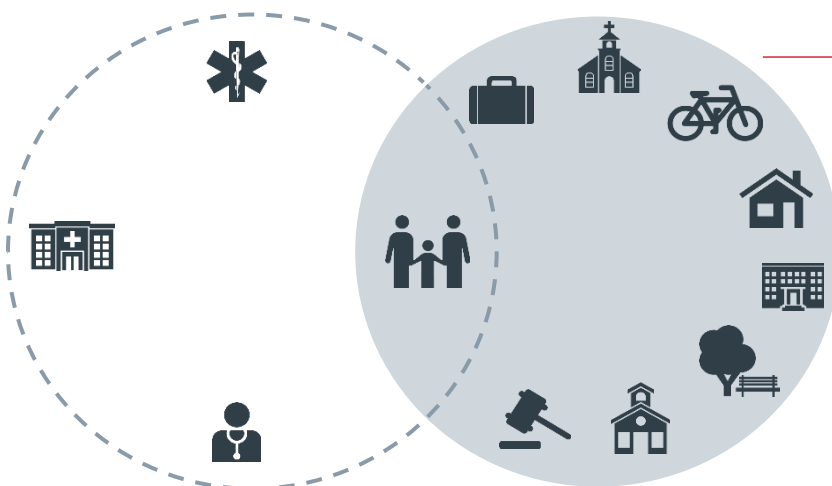
COMMON COMMUNITY INTERFACES

- Public health departments
- County mental health agencies
- School districts and universities
- Faith-based organizations
- YMCA/YWCA
- Service leagues (e.g., Lions, Rotary)
- Environmental organizations
- Local agencies (e.g., Area Agencies on Aging, housing and city planning departments)
- Local businesses (e.g., bodegas, barber shops)
- Non-profit service providers (e.g., Meals on Wheels, food banks)
- Public safety providers (e.g., police, EMS)
- Private firms (e.g., real estate and architecture firms)

Once the right community partner has been chosen for a specific intervention, partners have to discuss what type of partnership model to pursue in order to set a strong foundation and meet partnership goals.

Community partnership models fall on a continuum with a loose affiliation on one end and partial ownership on the other. Most community partnerships are informal, but those falling in between the two extremes are becoming more popular due to increased alignment. Shared ownership models, while less common, are setup when a high financial investment is at stake.

To explore community partnerships in more depth, Population Health Advisor members can review advisory.com/communitypartnerships