Core Competencies, Chapter 11

Measurement Based Care: Use of Adjusted Clinical Groups to Identifying/Stratifying High Risk Population

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Definition and Why Measurement Based Care and Identifying/Stratifying Population

The adjusted clinical group is the pivotal tool necessary for implementing population based care and optimizing measurement based care. It allows the care team to systematically integrated complex care management by identifying and stratifying population to identify patient's/client's utilization of services, demographics, diagnoses and target interventions for those who would benefit the most. The adjusted clinical group also tracks which patients/clients are not engaged in care and may benefit from more intensive services.

An Example of Use of the Adjusted Clinical Group Tool in Action

Patient 1: Low Cost Patient with Hypertension

Input Data/Patient Characteristics Resource Consumption Variables	Adjusted Clinical Group Output	Resource Consumption Variables
▪ Age/Sex: 51/Male	▪ ACG-0900: Chronic Medical, Total	▪ Cost: $128 Stable
▪ Conditions: Hypertension	▪ General ADGs: 10 and 31	▪ Ambulatory visits: 1
▪ Medical Exam	▪ Chronic Medical: Stable	▪ Emergency visits: 0
	▪ Preventions/Administrative	▪ Hospitalizations: 0

Patient 2: High Cost Patient with Hypertension

Input Data/Patient Characteristics Resource Consumption Variables	Adjusted Clinical Group Output	Resource Consumption Variables
▪ Age/Sex: 54/Male	▪ ACG-3600: Acute Minor/Acute Total	▪ Cost: $3,268
	▪ Major/Likely Recur/Eye & Dental	▪ Ambulatory visits: 1
▪ Conditions: Hypertension	▪ ADGS: 07,10,26, and 27 Disorders	▪ Emergency visits: 1
▪ Of Lipid Metabolism	▪ Likely to Recur: Discrete Chronic	▪ Hospitalizations: 0
▪ Low back pain, cervical pain	▪ Medical: Stable	
▪ Syndromes, Musculoskeletal signs	▪ Signs/Symptoms: Minor	
	▪ Symptoms Signs/Symptoms: Uncertain	

Narrative Description

The adjusted clinical group is a tool that groups people into one of six morbidity cohorts by a Risk Utilization Band score, from 5 representing "high utilization" to "1" representing healthy utilization, and provides a Predictive Model Risk Score (adjusted clinical group -PM) which is a probability score of representing high cost soon for an individual within a population.

The adjusted clinical group report provided by Inland Empire Health Plan can be used as a starting point to identify the top 5% of complex care clients by risk utilization band score by provider and by site. The adjusted clinical group reports helps to predict which clients are likely to be candidates for future high utilization, and thus possible strong candidates for your BHICCI target population. However, the adjusted clinical group alone isn't the final word on whether a client should be included within the

target population. Teams will refine the target population by other factors including: weather the clients are likely to benefit from complex care coordination, clinical input from team members, reviewing health care organizations reports/ data such as clinical values, functional assessments, information gathered from initial client interview(s) assessing the presence level of a mental health/substance abuse condition, and finally the patient's/client's willingness to engage in care and behavior change.

Available Resources

1. The Johns Hopkins Adjusted Clinical Group System
   http://acg.jhsph.org/index.php/component/content/article/95-about-the-acg-system/system-development/286-new-in-version-11
2. The Johns Hopkins Adjusted Clinical Group System Guide
   https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_035024.pdf

BHICCI Plan for Learning / Teaching / Coaching

The BHICCI team has a phased approach for the implementation and training in the use of care registries. Training in the importance and use of registries will be specific to organizational role and clinical assignments. Since use of clinical registries is new to most, clinicians involved in Integrated Complex Care ill receive individualized coaching throughout the BHICCI process. Once procedures are developed, focus will shift to maintaining and sustaining these clinical processes.

How will Competence in this area be Measured?

Following completion/verification of the above learning/teaching/coaching plan, each clinician will have the opportunity to practice his/her new skills under supervision. Following this, the supervisor will rate the clinician's competency in each of the following by:

1. Observation of the clinician sorting utilizing the registry, or
2. Observation of clinician presenting registry information at team meetings, or
3. Direct observation of clinician's interaction with teammates and/or patients/clients.

COMPETENCY AREA	EVIDENCED BY:	SUPERVISOR'S RATING*
Clinicians will have the ability to sort data in the adjusted clinical group at the caseload level.	• Demonstrate the ability to sort caseload data in the adjusted clinical group. • Demonstrate the ability to analyze data from the adjusted clinical group • Demonstrates evaluation of clinical outcomes and/or adjustments of care based on adjusted clinical group information.	1 2 3 4 5
The ability to identify which patients/clients would benefit additional attention at the weekly care team meetings.	• Effectively utilizes team meetings to present patients/clients who would benefit from staffing. • Demonstrates efficient use of data from adjusted clinical group's use during care team meetings.	1 2 3 4 5
The ability to effectively and efficiently present caseload adjusted clinical group data at weekly care team meetings.	• Communicates patient/client data and history clearly and efficiently. • Open and welcoming of feedback from team members on clients presented at team meetings. • Demonstrates clear documentation of case presentations at team meetings. • Documents follow through of patient/client staffing from team meetings.	1 2 3 4 5

*1= Excellent results with no need for prompting or support.
3 = good results and/or required some prompting or support.
5 =required much support and/or was unable to complete necessary skills.