



CareOregon

# Using ACGs for Population Management

## *“Dynamic ACGs?”*

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# CareOregon



- Medicaid Non Profit “Managed Care” Plan serving 100,000 under state capitation
  - 5.1% “standard” = very limited benefit
  - 94.9% “plus” = aged, blind, disabled, women & children
  - 82% live in the Portland Metro Area
  - 50% are seen in safety net clinics
- New Medicare Special Needs Plan – 5600 “duals”
  - 62% are under 65 yrs

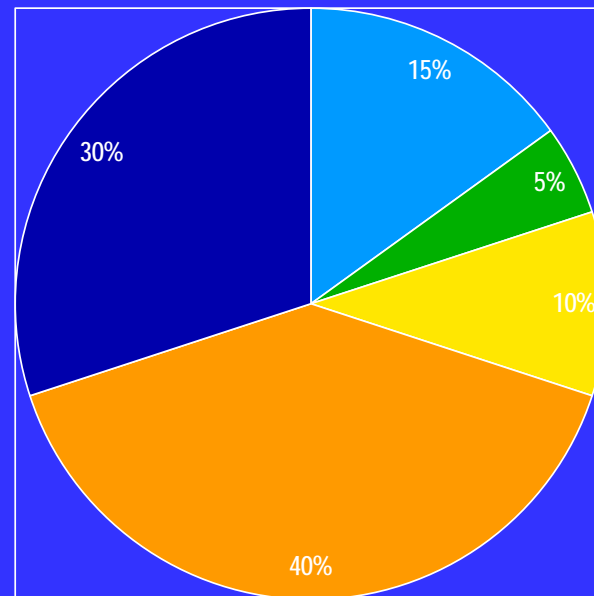
# Initiating Population Management: “CareSupport” Strategy

- Starting in 2003: initiate population management “at the top” with focus on high risk/ high cost members.
- Goal: improve the health outcomes and cost for the top 3% -- 3000 members - who use 30% of dollars; then impact the top 12% who use 60%
- Goal: move from reactive, crisis management to proactive risk reduction starting with the highest risk, moving over time to lower risk and prevention.

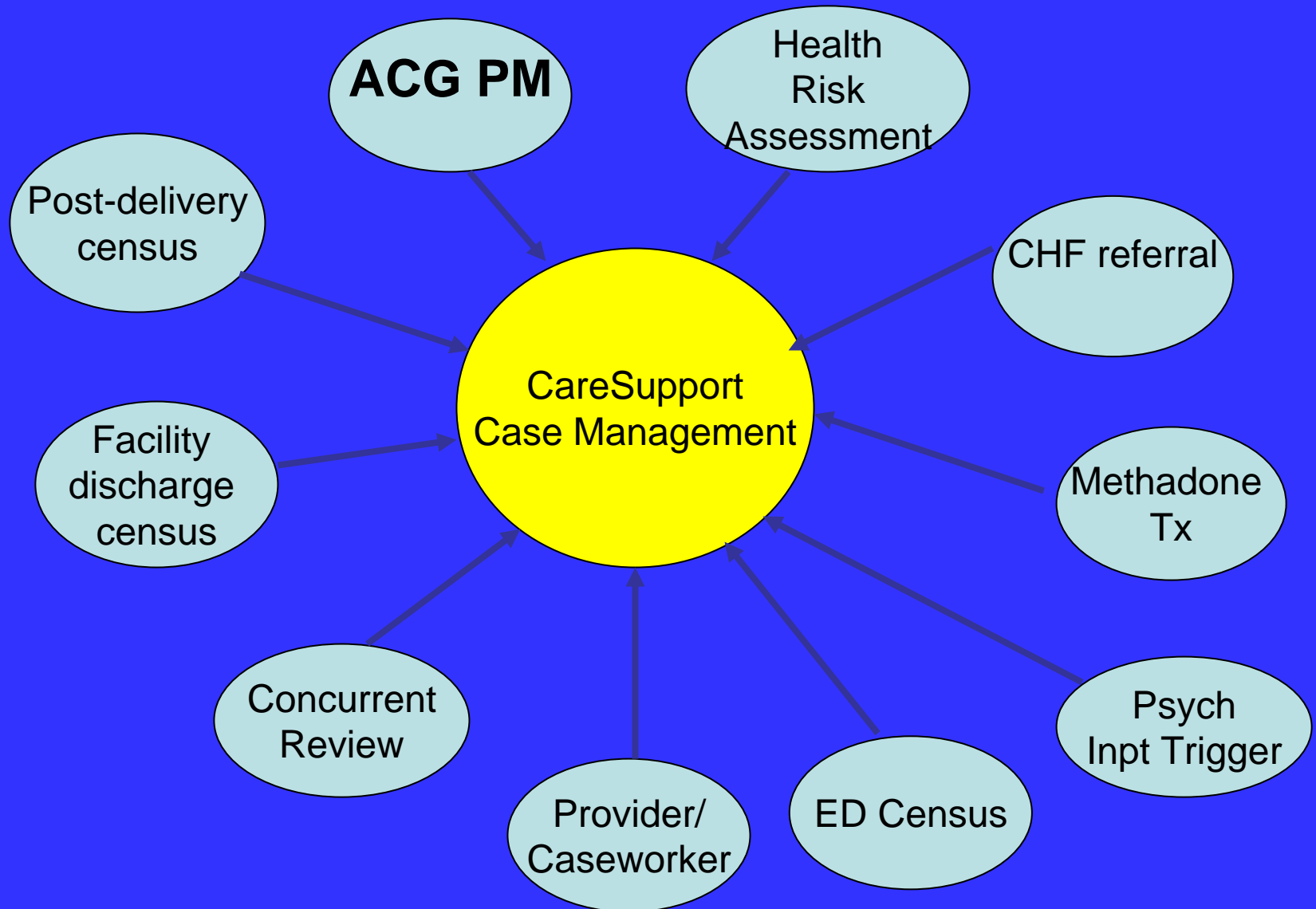
# CareSupport Principles



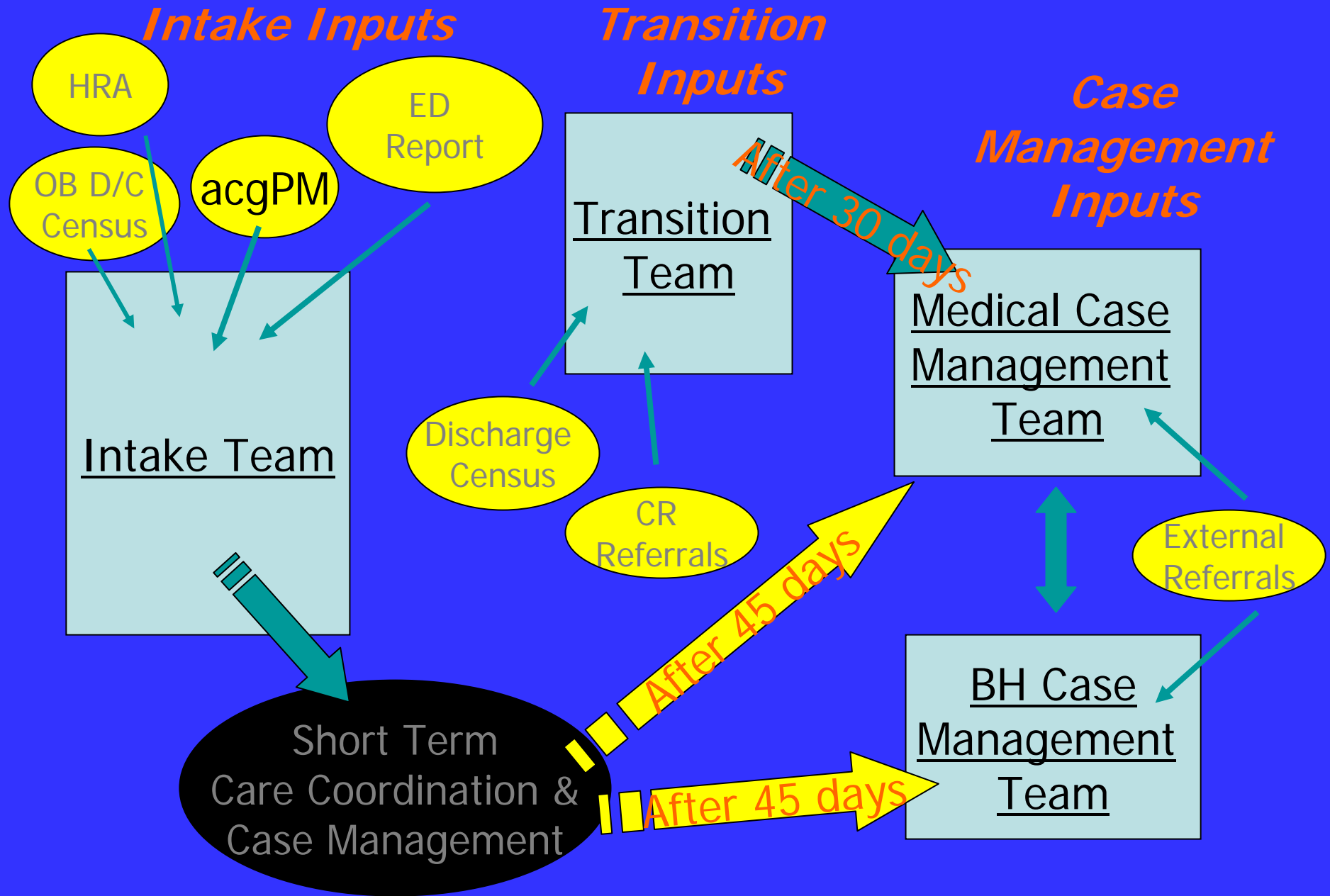
- **Holistic, person-centered:**  
members are more than a single disease;  
biopsychosocial model puts context and social morbidity as important drivers of risk
- **Team-based:**  
multidisciplinary teams care for members;  
comprehensive behavioral-health integration and pharmacy integration



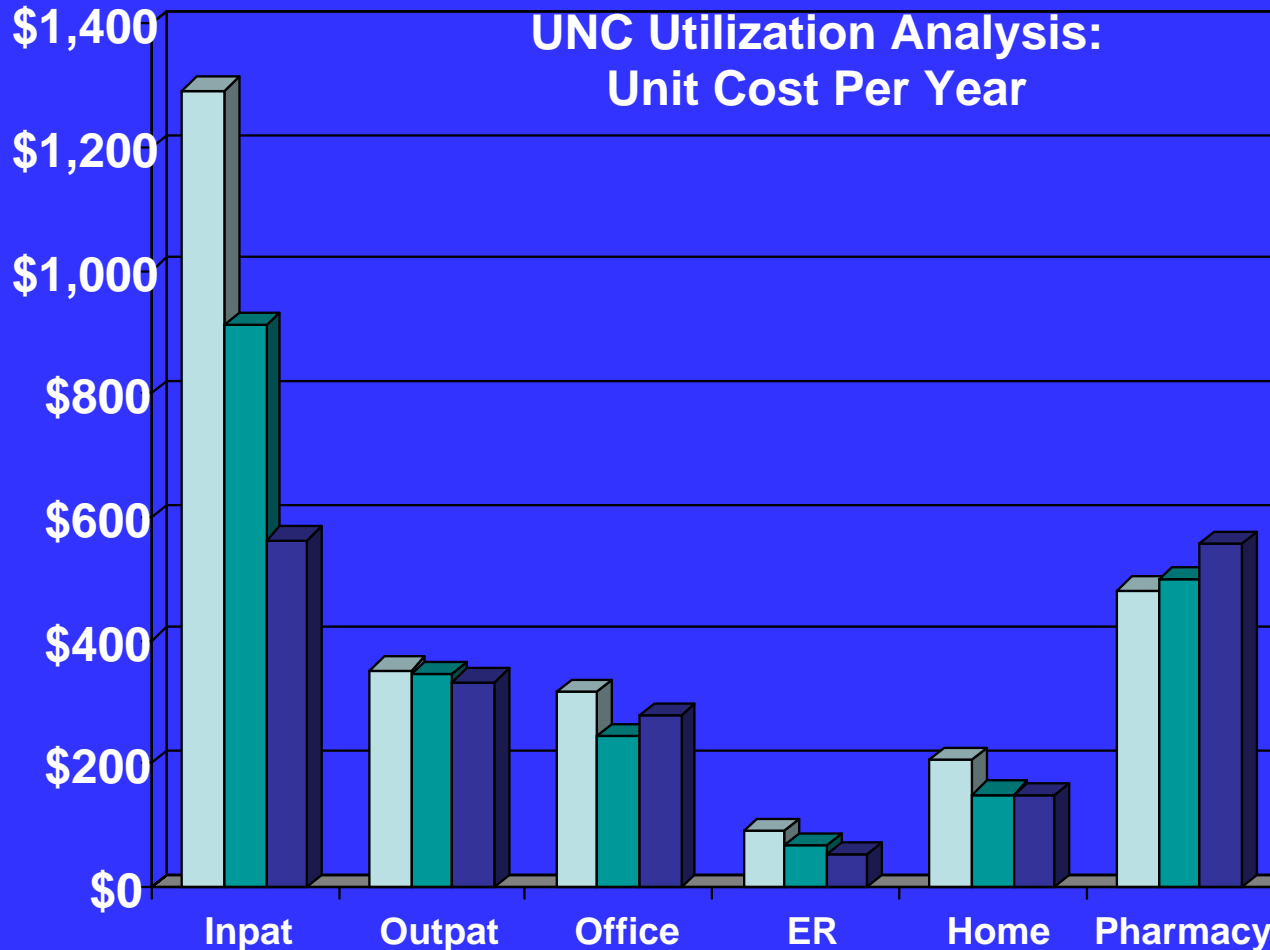
# Proactive technology and outreach capabilities



# Unit Workflow



# Measurement at the Population: PMPM for CareSupport



Total Payments  
\$2,815 baseline  
\$2,261 year one  
\$1,963 year two

■ Baseline  
■ Year 1  
■ Year 2

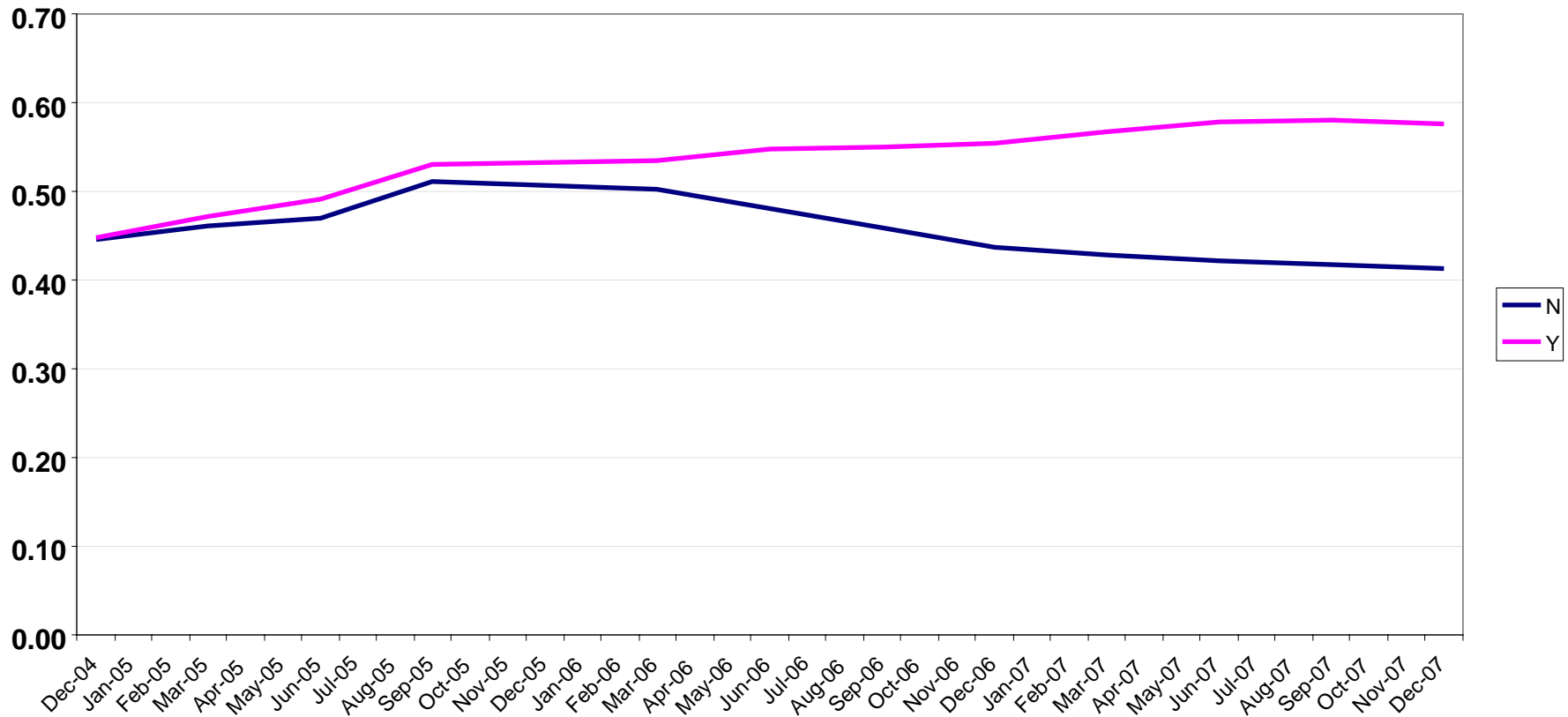
# Rethinking ACG PM Scores

- With multiple years of population data can, what can we learn from a longitudinal view?
- ACG scores predict *medical* acuity: scores should increase as acuity increases
- What happens to ACG scores over time?
- Individual scores:

	Dec-04	Mar-05	Jun-05	Sep-05	Dec-05	Mar-06	Jun-06	Sep-06	Dec-06	Mar-07	Jun-07	Sep-07	Dec-07
A A A	0.139	0.139	0.085	0.149	0.771	0.143	0.255	0.470	0.855	0.792	0.635	0.368	0.750
B B B	0.119	0.147	0.166	0.218	0.724	0.406	0.309	0.622	0.552	0.576	0.261	0.235	0.235
C C C	0.912	0.916	0.974	0.966	0.991	0.991	0.982	0.918	0.833	0.910	0.925	0.901	0.922
D D D	0.380	0.480	0.692	0.746	0.864	0.896	0.739	0.556	0.617	0.498	0.468	0.536	0.525
E E E	0.174	0.221	0.347	0.347	0.890	0.452	0.788	0.791	0.855	0.875	0.886	0.666	0.604

# Those $>.5$ ACGs “Enrolled” Maintain Hi Scores vs Non Enrollees

Those enrolled in Care Management since Jan 07 (Y) vs. others (N)  
All had risk scores for the entire period and at least 1 score over .5  
December 2005 is excluded from Graph

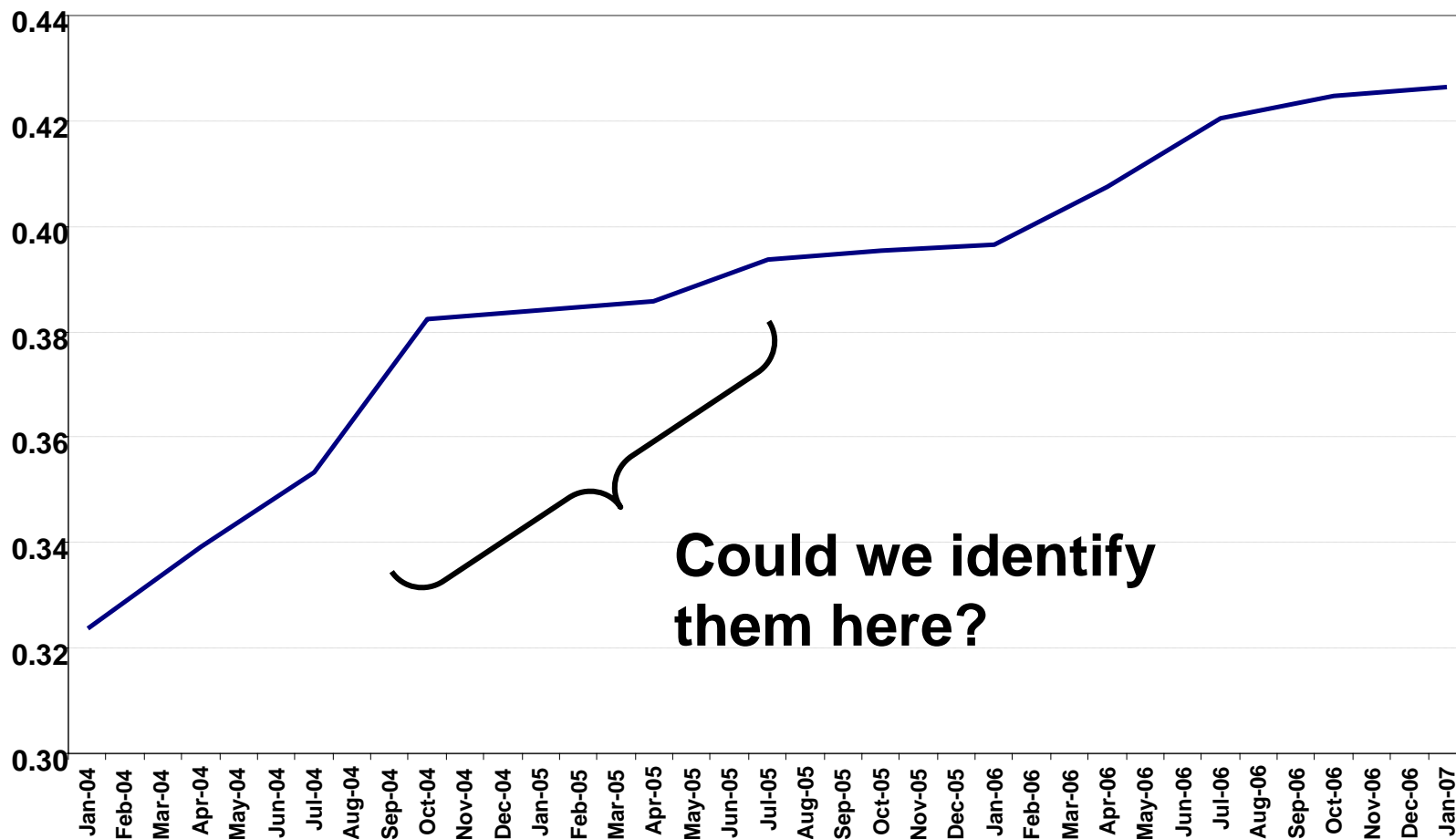


# “Dynamic ACGs?”

- Can we use *ACG change* as means for early identification of those with increasing medical co morbidity?
- Setting ACG case finding threshold lower finds too many “candidates”
  - ACG .4 - .5 found 3000
- How do we sort?

# Change in “Hi Risk Group” Average ACG Score Over Time

Change in rolling year average ACG score (by beginning month of claims period)  
Those enrolled in Case Management after January 2007 n= 952

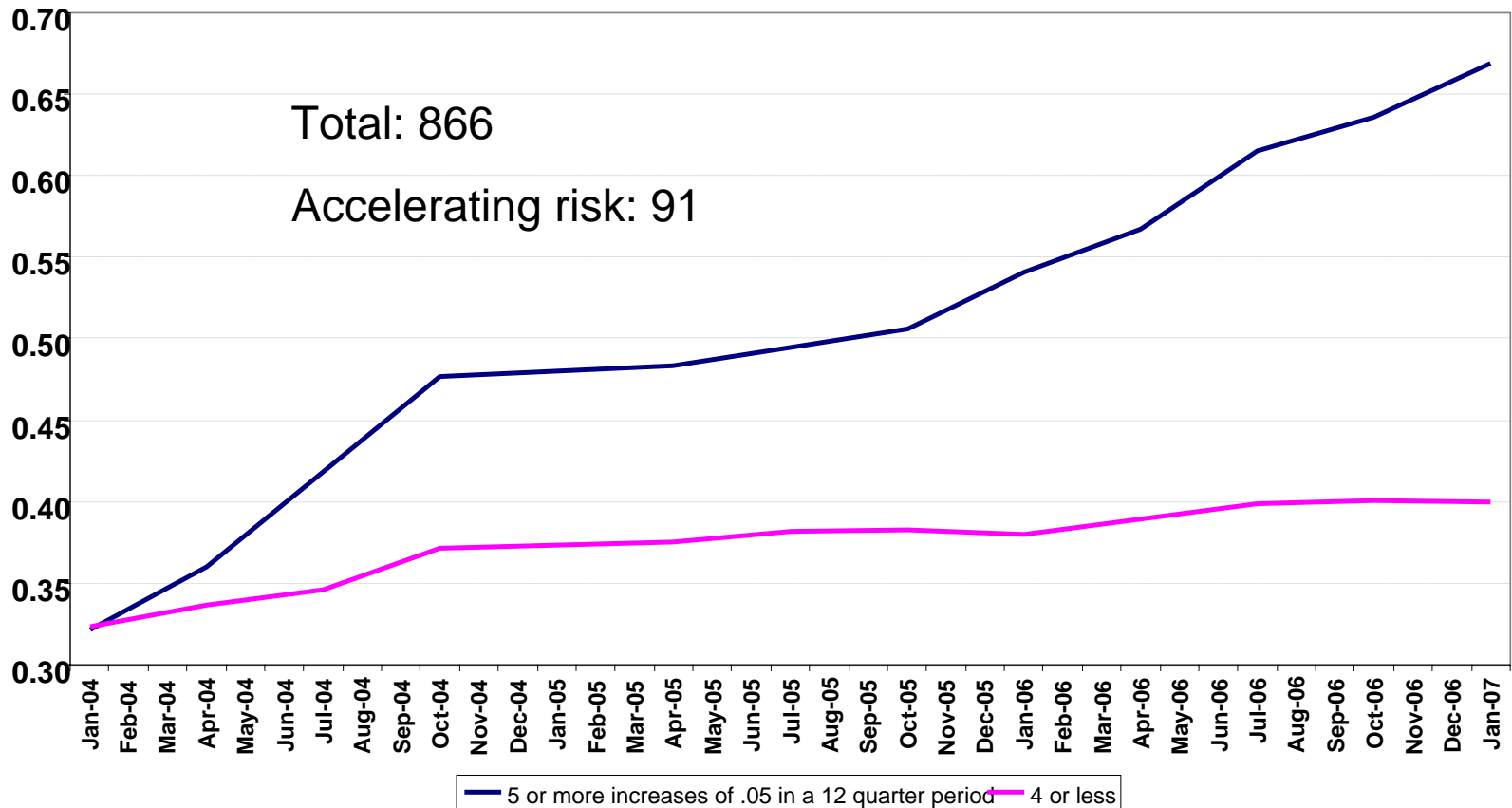


# Accelerating Risk Group

Change in rolling year average ACG score (by beginning month of claims period)

Those enrolled in Case Management after January 2007

Those with 5 or more increases of .05 from one period to the next in a 12 quarter period vs. those with less than 5



# Case Study

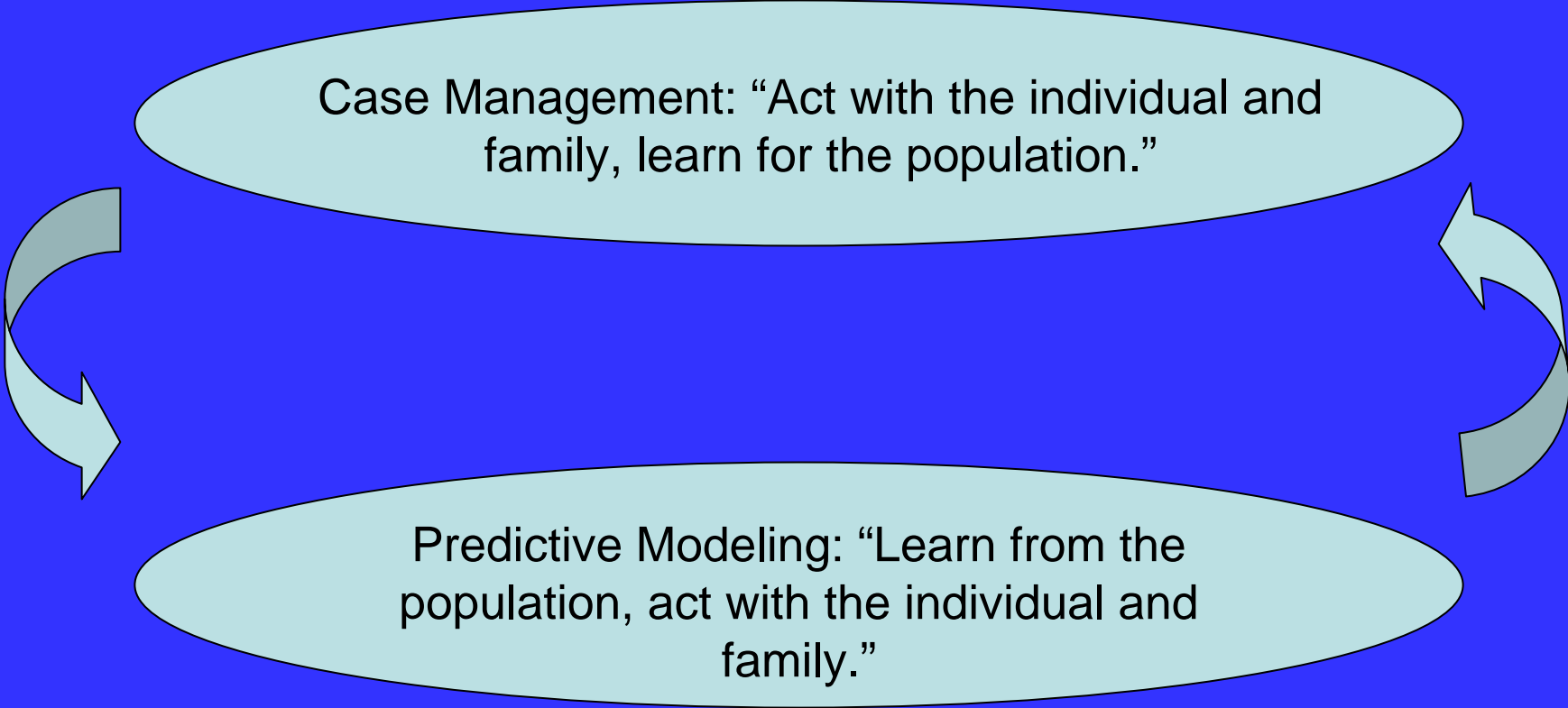


- 40 yo female; disabled hairdresser 2<sup>nd</sup> hand pain; primary caregiver of sister with mental delay
- ACGs
  - 12/04 = 0.35... 9/05 = 0.35. 6/06 = 0.5
- 2004:
  - Initial notes: Congenital Heart Disease s/p valve replacement (20 y/o) on anticoag; Fibromyalgia (1999); Depression; Obesity, Hypertension, Tobacco
  - 6/04 New Diabetes 2
  - 7/04 GI Bleed ?NSAIDS
  - 11/ 04 Migraine
  - 12/04 Sleep disorder
- Aggressive medication management for all condtions
  - Fibromyalgia RX failures : Mestinon, Aricept, Topamax, Requip (spasm).
  - Intolerant of antidepressants
- On increasing amounts/ types of opioids, increasing problems

# Case Cont...

- 2/05 Pain Clinic for chronic right sided throat pain: notes marijuana use, panic attacks, social phobias, cognitive deficits ? from meds; referred to psych
- 5/05 Sleep Disorder Clinic for poor sleep; sleep apnea ruled out
- 8/05 Request for housekeeper 3x wk; denied when missed caseworker appt
- 12/05 Diabetes Clinic: Not testing sugars as no glucometer
- 4/06 Irritable Bowel Syndrome
- 4/07 Diverticular Bleed inpatient x 2 weeks
- 6/07: Enrolled in case management from ACG query:
  - Unsatisfied with care; pcp took away medical marijuana card – using for chronic pain; needs housekeeper (had but taken away); PHQ 9 = 17

# “Dynamic ACG Analysis:” Earlier Case Finding?



Case Management: “Act with the individual and family, learn for the population.”

The diagram consists of two light blue ovals with black outlines, one above the other. The top oval contains the text 'Case Management: “Act with the individual and family, learn for the population.”'. The bottom oval contains the text 'Predictive Modeling: “Learn from the population, act with the individual and family.”'. On the left side, a curved arrow points from the top oval down to the bottom oval. On the right side, a curved arrow points from the bottom oval up to the top oval, creating a clockwise cycle.

Predictive Modeling: “Learn from the population, act with the individual and family.”

Thank You!



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