



Targeted
Investments

Core Component # 2 for Adult Primacy Care Provider

Identifying members who are
High Risk and tracking them
through an electronic High Risk
Registry



Key Concepts for the High Risk Registry

- Patients that are known as High Needs/High Cost are usually identified based on multiple data elements such as hospitalizations, claims history, high volume office contacts, etc.
- The electronic registry can be in a variety of formats, ranging from a spreadsheet to a sophisticated report.
- Using multiple data sources, the practice will identify which health risks or factors/scores/criteria it will use to populate its High Risk Registry.
- The High Risk Registry is the tool a practice will use to identify, monitor and intervene on the subset of patients who are at the highest risk of hospitalizations or deteriorating health within the next 12 months.
- The High Risk Registry tracks the highest risk patients whose long-term health outcomes can be positively affected with appropriate interventions.

Additional Information on the High Risk Registry

- The Registry can be maintained inside or outside the electronic health record.
- Practices can determine which Adult members are at high risk but **MUST** include members with or at risk for a behavioral health condition who are at high risk of:
 - a.) near term acute and behavioral health service utilization and
 - b.) decline in physical and/or behavioral health status and
 - c.) are at medium to high criminogenic risk as determined by probation/parole and the appropriate criminogenic screenings

Review of Core Component #2

2. Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated care management. Practices should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), electronic health record (EHR)-based analysis of members with distinguishing characteristics, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current (Arizona Health-e Connection). Practices should prioritize members within the registry whose status may be improved or favorably affected through practice-level care management.¹

The registry may be maintained inside or outside of the electronic health record.

Adult members at high risk are determined by the practice, but must include members with or at risk for a behavioral health condition who are at high risk of a) near-term acute and behavioral health service utilization and b) decline in physical and/or behavioral health status.

Milestone Measurement Period 1

(October 1, 2017–September 30, 2018*)



Practice Reporting Requirement to State

- A. By August 31, 2018, demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk members, AND
- B. By September 30, 2018, demonstrate that the high-risk identification criteria are routinely used, and that the names and associated clinical information for members meeting the practice criteria are recorded in the registry.

Milestone Measurement Period 2

(October 1, 2018–September 30, 2019*)



Practice Reporting Requirement to State

By September 30, 2019, demonstrate that the care manager is utilizing the practice registry to track integrated care management activity and member progress, consistent with Core Component 3A and/or 3B.

TI Year 2 Measurement Period

October 1, 2017 – September 30, 2018

Practice requirement to the state:

By August 31, 2018

Demonstrate that a high risk registry has been established and articulate the criteria used to identify high-risk members.

AND

Demonstrate that the high-risk identification criteria are routinely used, and that the names and associated clinical information for members meeting the practice criteria are recorded in the registry.

Attestation and Document Validation

- AHCCCS will be opening a TI Attestation Portal through **AHCCCS Online**
<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f>
- The portal will be available for milestone attestation and document upload in June 2018
- Not all of the Milestones will require providers to upload documentation through the Attestation Portal for review by AHCCCS.
- In order to attest for this milestone, participants will need to submit the criteria used to build their high risk registry.
- More detailed information and guidance about how to use the TI Attestation Portal will be available prior to June 2018.

Sneak Peek into TI Year 3





Sneak Peek: TI Year 3 Measurement Period

October 1, 2018 – September 30, 2019

2. Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated care management. Practices should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), electronic health record (EHR)-based analysis of members with distinguishing characteristics, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current (Arizona Health-e Connection). Practices should prioritize members within the registry whose status may be improved or favorably affected through practice-level care management.¹

The registry may be maintained inside or outside of the electronic health record.

Adult members at high risk are determined by the practice, but must include members with or at risk for a behavioral health condition who are at high risk of a) near-term acute and behavioral health service utilization and b) decline in physical and/or behavioral health status.

Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*)  Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2018–September 30, 2019*)  Practice Reporting Requirement to State
A. By August 31, 2018, demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk members, AND B. By September 30, 2018, demonstrate that the high-risk identification criteria are routinely used, and that the names and associated clinical information for members meeting the practice criteria are recorded in the registry.	By September 30, 2019, demonstrate that the care manager is utilizing the practice registry to track integrated care management activity and member progress, consistent with Core Component 3A and/or 3B.

Sneak Peek: TI Year 3 Measurement Period; October 1, 2018 – September 30, 2019

Reporting Requirement to the State:

By September 30, 2019:

demonstrate that the care manager is utilizing the practice registry to track integrated care management activity and member progress, consistent with Core Components #3A and or 3B- Care Manager Core Component.

Questions?

Please contact us at
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if you have any questions



Thank You.

