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Workgroup's Recommendations Help HMOs Identify and Care for, High-Risk Chronically Ill Older Patients

HMO care management workgroup: Transitions of care

SUMMARY

For 10 years (1994–2004), the HMO Workgroup on Care Management published recommendations on, and highlighted opportunities and challenges in, care management practices for chronically ill older patients under capitated arrangements—those in which the provider is paid a fixed amount for a patient over a given period no matter what the actual number or nature of services delivered.

The workgroup was composed of representatives from selected health plans and capitated group practices and researchers (see Appendix 1 for a list of members).

The Robert Wood Johnson Foundation (RWJF) supported this project—first as part of the national program *Chronic Care Initiatives in HMOs*, and then, after the program ended, through grants to the Washington-based AAHP Foundation (now called America's Health Insurance Plans [AHIP]). The project director estimates that the workgroup cost a little over $1 million paid from these grants.

Key Result

The HMO Workgroup on Care Management generated documentable improvements in care for chronically ill seniors in major health plans and capitated medical groups (e.g., Kaiser Permanente, Lahey Clinic, Group Health Cooperative of Puget Sound, Oxford Health Plans).

For detailed results of this project, see Results.

Key Recommendations

Managed care organizations should:

- Find ways to identify, assess and plan for care for chronically ill seniors.

- Establish partnerships with community agencies that provide complementary services for older members with common geriatric conditions.
- Provide both practitioners and members with specific tools and guidance to enhance the functioning and quality of life of older members. It focused on seven common problems:
  - Physical inactivity.
  - Falls.
  - Depression.
  - Medication-related complications.
  - Urinary incontinence.
  - Under-nutrition.
  - Dementia.
- Establish performance standards for transferring patients among care settings and monitor performance against these standards.
- Develop and maintain user-friendly information systems that facilitate practitioners' ability to access necessary data elements and communicate with one another across the continuum of care.

See Selected Recommendations and Appendices 3, 4, 5 and 6 for further, detailed recommendations.

Funding

RWJF provided seven grants totaling $1,698,670 from November 1994 to June 2004.

THE PROBLEM

About 10 percent of all older adults have multiple heath care needs and are at high risk for poor quality of life and the use of expensive health-related services. They account for 70 percent of health care costs for all older adults, according to the federal Centers for Medicare & Medicaid Services. HMOs can improve outcomes for these older adults by identifying them and providing appropriate care. However, the competitive business environment discourages HMOs from collaborating to make health care more effective.

CONTEXT

RWJF has been involved in improving chronic illness care since its inception in 1972.

In 1993, RWJF launched the national program *Chronic Care Initiatives in HMOs*, which sought to identify, demonstrate, evaluate and disseminate innovations in the health care of chronically ill people enrolled in prepaid managed care organizations. See the Program Results Report on this program.

The AAHP Foundation was the national program office. Peter Fox, PhD, served as the program's director. The AAHP Foundation was the educational, scientific and research arm of the American Association of Health Plans, the national association representing nearly 1,300 health insurance companies (In 2004, the association merged with the Health Insurance Association of America to become America's Health Insurance Plans, and the foundation was renamed the AHIP Foundation). *Chronic Care Initiatives in HMOs* ended in 1997.

THE PROJECT

Staff from the national program office of *Chronic Care Initiatives in HMOs* established the HMO Workgroup on Care Management in 1994 to:

- Create an environment in which participants can openly and candidly exchange information on care management practices for chronically ill older adults at a detailed and operational level.
- Identify or develop a screening questionnaire for classifying the risk status of seniors in HMOs.

RWJF funded their work with grant ID#s 021989, 026408, 026625 and 028596. When the national program closed in 1997, RWJF continued to support the workgroup through grants to the AAHP Foundation (ID#s 032493, 037564 and 043561).

At quarterly meetings, members of the HMO Workgroup on Care Management exchanged information, developed recommendations on, and highlighted opportunities and challenges in, care management practices for chronically ill older patients.

The workgroup was typically composed of eight senior managers from managed care organizations (health plans and group medical practices) and two university-based geriatric researchers (see Appendix 1 for a list of members). Each managed care organization enrolled many older adults under Medicare capitation. Under this system, Medicare pays a fixed amount:

- For a patient regardless of actual services delivered, or
- Per enrollee to cover a defined set of services over a specified period, regardless of the actual services provided.

Publishing Activities

The HMO Workgroup on Care Management published eight reports (several of which were the basis for articles in the *Journal of the American Geriatric Society, Annals of Long-Term Care, American Journal of Managed Care* and various non-peer-reviewed journals). See Results for details.

Project staff distributed these to:

- Members of America's Health Insurance Plans (AHIP), which represents the merger of the Health Insurance Association of America (HIAA) and the American Association of Health Plans (AAHP).
- American Medical Group Association.
- Aging organizations.
- The media.
- Selected Congressional staff.
- Consumer organizations.
- Health and long-term care provider associations.

Project staff posted the reports to America's Health Insurance Plans website. See the Bibliography for details.

Other Funders

Ross Products, a Division of Abbott Laboratories, Inc. ($75,000), BlueCross and BlueShield Association ($10,000), Anthem BlueCross and BlueShield of Connecticut ($10,000) and Oxford Health Plans ($10,000) also funded the project.

RESULTS

The HMO Workgroup on Care Management generated documentable improvements in care for chronically ill seniors in major health plans and capitated medical groups (e.g., Kaiser Permanente, Lahey Clinic, Group Health Cooperative of Puget Sound, Oxford Health Plans). Specifically, as reported in published reports and reports to RWJF:

- **The HMO Workgroup on Care Management proposed approaches to identifying, assessing and planning the care of high-risk seniors.** One effect was a significant increase in the number of health plans that screened members to identify those that were at high risk and develop treatment plans for them.
  - For more information, see *Identifying High-Risk Medicare HMO Members: A Report from the HMO Workgroup on Care Management* (April 1996). See also

Planning Care for High-Risk Medicare HMO Members (July 1997); "Essential Components of Geriatric Care Provided through Health Maintenance Organizations," published in the *Journal of the American Geriatrics Society* (1998); *Geriatric Case Management: Challenges and Potential Solutions in Managed Care Organizations* (January 1999); and *Risk Screening Medicare Members Revisited* (February 2000).

- **The HMO Workgroup on Care Management addressed ways to improve the care of older adults with common geriatric conditions.** The workgroup made recommendations on ways to enhance the functioning and quality of life of older members. It focused on seven common problems:

  — Physical inactivity.

  — Falls.

  — Depression.

  — Medication-related complications.

  — Urinary incontinence.

  — Under-nutruition.

  — Dementia.

  For more information, see *Recommendations and Improving the Care of Older Adults with Common Geriatric Conditions* (February 2002).

- **The HMO Workgroup on Care Management addressed ways to improve the quality of transitions among care settings for members with complex care needs.** The workgroup made recommendations to improve care delivered to patients who are moving between care settings. They include: hospitals, skilled nursing facilities, the patient's home, outpatient primary care and specialty clinics, and assisted living and other long-term care facilities. Recommendations covered:

  — Accountability.

  — Information needs.

  — Practitioner skills sets and the support system.

  — Patient and caregiver preparation.

  — Financial incentives and structural issues.

  Several organizations restructured themselves internally to address problems of health care transitions among sites of care (e.g., hospital, nursing home, assisted living, private home). Problems include poor communication among providers at different sites of care, patient misunderstanding of medical orders, lack of primary care at

nursing homes in the initial days of a patient's stay and each site having a different drug formulary.

For more information, see Selected Recommendations, Appendices 3, 4, 5 and 6 and *One Patient, Many Places: Managing Health Care Transitions* (February 2004).

- Five other HMO Workgroup reports addressed:
  - Planning care.
  - Essential components of geriatric care.
  - Relationships with community organizations.
  - Geriatric case management.
  - Risk screening (revisited).

  (See Appendix 2 for report descriptions).
- **The HMO Workgroup on Care Management made virtually universal the number of health plans that screened new members for chronic conditions using scientifically validated instruments and that instituted measures to identify existing members (i.e., those with experience in the plan) who had chronic conditions.**
  - This response by health plans had a major impact on a new congressional regulation that all HMOs screen new members for chronic conditions.
- **The HMO Workgroup on Care Management increased awareness at the individual provider level of the need to address common geriatric conditions, such as physical inactivity, incontinence, falls and malnutrition, and provided tools for providers to do so.**

SELECTED RECOMMENDATIONS

The HMO Workgroup on Care Management made the following recommendations for managed care organizations:

Recommendations on Improving Care for Common Geriatric Conditions

From *Improving the Care of Older Adults with Common Geriatric Conditions* (February 2002). Recommendations fall into eight categories; one recommendation from each is noted here; for the complete recommendations from this report, see Appendix 3:

- *General Recommendations:* Conduct periodic screening and assessment for common geriatric conditions and have effective interventions in place for positively identified older members.

- *Physical Inactivity:* Promote physical activity for members irrespective of age, health or functional status. Physical activity is particularly important for members with chronic illness, who are at high risk for functional dependence. It is also particularly important for those contemplating elective surgery, such as knee replacement.
- *Falls:* Adopt mechanisms to identify older members who have fallen in the past year or who are at high risk for falls and associated injuries—given that over 30 percent of community-dwelling older adults fall at least once each year.
- *Medication-Related Complications:* Implement programs targeting medication-related complications for older members, irrespective of whether they offer a pharmacy benefit. Such programs should target overuse, underuse and misuse of medications.
- *Dementia:* Work with practitioners and members to increase awareness of dementia to facilitate early identification and appropriate management.
- *Depression:* Heighten awareness among both members and practitioners of the impact of depression on quality of life and on the management of other acute and chronic conditions.
- *Under-nutrition:* Educate practitioners regarding the central role of under-nutrition in chronic disease management and functional rehabilitation.
- *Urinary Incontinence:* Seek to identify older members with urinary incontinence and initiate effective treatment.

Recommendations on Health Care Transitions

From *One Patient, Many Places: Managing Health Care Transitions* (February 2004). Recommendations fall into five categories; one recommendation from each is noted here; for the complete recommendations from this report, see Appendix 4.

- *Accountability:* Establish performance standards for transferring patients among care settings and monitor performance against these standards.
- *Information Needs:* Define the essential data elements needed to provide high-quality care to members who are transitioning across sites of care.
- *Practitioner Skill Sets and Support Systems:* Improve practitioner knowledge of the services and settings available across the continuum of care to facilitate the best match between a patient's care needs and the care setting.
- *Patient and Caregiver Preparation:* Identify patients likely to require care transitions in the near future and engage them and their caregivers in pre-transition planning.
- *Financial Incentives and Structural Issues:* Ensure that financial incentives among providers are aligned to promote:

- High-quality care transitions.
- The transmission of essential data elements to practitioners involved in a patient's care across different settings.

Recommendations on Planning Care for High-Risk Medicare HMO Members

From *Planning Care for High-Risk Medicare HMO Members* (1997)

- Health plans should conduct an initial assessment that includes: cognitive function, diagnoses/medical conditions, medications, care access, functional status, social situation, nutrition and emotional function. Highly trained and experienced case managers (e.g., nurses) should perform the assessment.
- If the initial assessment indicates that an older member has complex needs and problems that may be modifiable, clinical staff should perform a detailed assessment for use in developing and prioritizing specific plans for addressing the potentially modifiable problems. The assessment should be:
  - Consistent (facilitated by using standardized assessment instruments).
  - Expert (facilitated by using qualified professionals).
  - Efficient (facilitated by defined procedures and roles).
  - Productive (facilitated through close linkages with tailored interventions).

Recommendations on Essential Components of Geriatric Care Provided by HMOs

The HMO Workgroup on Care Management identified the essential components of geriatric care in HMOs in "Essential Components of Geriatric Care Provided Through Health Maintenance Organizations" (*Journal of the American Geriatrics Society*, 1998). They include:

- A systematic program for identifying HMO enrollees at high risk for adverse health outcomes.
- A geriatric case management program that serves high-risk enrollees in all settings—including clinic, home and institution—to promote functional independence, prevent functional decline, enhance quality of life and ensure the appropriate use of health services.
- Geriatric expertise for designing and administering geriatric programs and for consultation with primary care physicians, case managers and other providers.

For the other components see Appendix 5.

Recommendations on Risk Screening Medicare Members

Risk Screening Medicare Members Revisited (2000) includes seven recommendations. All are listed in Appendix 6. They include:

- Health plans should perform risk identification as a central component of population-based care for new and existing older members.
- Health plans should select self-report questionnaires and risk indices based upon their intended purpose and use, including identifying high-risk members and planning service delivery.
- Health plans should use rigorously developed, validated self-report questionnaires for identifying high-risk new members. The Pra™ (which measures the probability of repeat hospital admissions) and the Frailty Score (which measures the probability of long-term care needs) are two examples.

CONCLUSIONS

Establishing Relations with Community Organizations: An Imperative for Managed Care Organizations Serving Medicare Beneficiaries (1999) contains the following conclusions:

- Whether the managed care organization is coordinating access to services with community organizations, or paying for non-covered benefits through these agencies, resources are involved. The willingness of managed care organizations to bear costs is premised upon the potential for improving health outcomes and perhaps achieving reduced service use. Managed care organizations must align the incentives of the parties that affect service delivery.
- Managed care organizations need to address the issue of responsibility and payment for case management of members, possibly by establishing guidelines. "The principal focus for making arrangements between the [managed care organization] and the community organization is typically the case management staff at the managed care company, although primary care physicians and others also play a role."
- Better integration between Medicare and Medicaid is essential. Some 6 million Americans are eligible for both programs. However, current federal policy makes it difficult for states to encourage or mandate that Medicaid beneficiaries enroll in Medicare risk plans or for managed care organizations to assume responsibility for providing both Medicare and Medicaid benefits.
- Managed care organizations need to recognize that many community organizations have inadequate funding or weak management, and poor interagency communication. They should work with others locally to foster improvements.

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[1] Grant ID#s 021989, 026408, 026625, and 028596 were mainly used to provide technical assistance and direction to the RWJF national program, *Chronic Care Initiatives in HMOs*, under which the HMO Workgroup on Care Management started.

APPENDIX 1

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APPENDIX 2

HMO Workgroup Reports and Articles

(Current as of the end date of the program; provided by the program's management; not verified by RWJF.)

- *Planning Care for High-Risk Medicare HMO Members* (July 1997). This report presents a geriatric care management process from case finding (i.e., the identification of patients who need to be followed more closely) through assessment. It describes steps to take after identifying older members as high risk.
- "Essential Components of Geriatric Care Provided Through Health Maintenance Organizations" (1998). Published in the *Journal of the American Geriatrics Society* in 1998, the article describes the types of services that should realistically be available to older adults who are enrolled in an HMO with a Medicare risk contract in order to

meet the goals of geriatric care—to promote health, independence and optimal functioning; to prevent avoidable decline in health status; and to enhance quality of life.

- *Establishing Relations with Community Organizations: An Imperative for Managed Care Organizations Serving Medicare Beneficiaries* (January 1999). The report explores ways in which managed care organizations can go beyond the pure medical model by developing linkages with community-based social services agencies—on both the individual level (i.e., a case manager arranging for services for a member) and the organizational level (i.e., formal relationships between the managed care organization and community-based organizations).
- *Geriatric Case Management: Challenges and Potential Solutions in Managed Care Organizations* (January 1999). The report covered seven areas of special concern in regards to case management programs:
  - Primary care physician and care team roles.
  - Delivery and system benefits.
  - Member and family relationships.
  - Linkages to home and community-based services.
  - Staffing levels and case management skills.
  - Establishing goals and measuring outcomes.
  - Discharge from case management.
- *Risk Screening Medicare Members Revisited* (February 2000). The report identifies the ways in which older adults are at risk of functional status decline and health resource utilization (for example, hospitalization, emergency services and home health care). It focused primarily on three issues:
  - Self-report instruments used for newly enrolled members.
  - The potential for improving the health of older members with geriatric conditions that may not require comprehensive case, such as management of physical inactivity and incontinence.
  - The impact of provider referral, using administrative data to monitor risk, and identifying risk via member or caregiver self-referral.

APPENDIX 3

Recommendations for Managed Care Organizations from Improving the Care of Older Adults with Common Geriatric Conditions (February 2002)

General Recommendations

- Conduct periodic screening and assessment for common geriatric conditions and have effective interventions in place for positively identified older members.
- Ensure that primary care practitioners have the tools, incentives and resources to facilitate identification and appropriate management of older members with common geriatric conditions.
- Establish partnerships with community agencies that provide complementary services for older members with common geriatric conditions.
- Recognize that geriatric conditions often confound treatment of other chronic illnesses.
- Be open to innovations that are not currently part of the benefit structure but may have a positive impact on quality of life for older members.

Physical Inactivity

- Promote physical activity for members irrespective of age, health or functional status. Physical activity is particularly important for members with chronic illness, who are at high risk for functional dependence. It is also particularly important those contemplating elective surgery, such as knee replacement.
- Increase awareness of the benefits of physical activity among older members and encourage them to discuss physical activity with their primary care practitioner.
- Provide both practitioners and members with specific tools and guidance to promote regular physical activity.
- Establish partnerships with community-based agencies to ensure that physical activity programs are available to their members. Managed care organizations should also participate in state- or citywide initiatives designed to promote physical activity.

Falls

- Adopt mechanisms to identify older members who have fallen in the past year or who are at high risk for falls and associated injuries—given that over 30 percent of community-dwelling older adults fall at least once each year.
- Heighten awareness among members and providers of the significance of falls and provide interventions tailored to their level of risk.

- Ensure that interventions are available that address the following four risk areas associated with falls: high-risk medications, deconditioning (i.e., muscle atrophy), home and environmental safety and visual impairment.
- Participate in statewide initiatives aimed at reducing fall-related injuries.

Medication-Related Complications

- Implement programs targeting medication-related complications for older members, irrespective of whether they offer a pharmacy benefit. Such programs should target overuse, underuse and misuse of medications.
- Improve compatibility of internal and external data systems to maximize the potential use of administrative data (diagnosis, pharmacy and utilization) for targeted interventions.
- Employ pharmacists in a liaison role between pharmacy benefit managers, practitioners and members.
- Provide educational materials and tools to practitioners and members designed to reduce medication-related complications.

Dementia

- Work with practitioners and members to increase awareness of dementia to facilitate early identification and appropriate management.
- Enhance practitioners' ability to diagnose and manage dementia by:
  - Providing education.
  - Facilitating linkages to community agencies and caregiver support groups.
  - Increasing awareness of the negative effect of dementia on the management of comorbid conditions-to promote the highest level of functional independence possible.
- Involve the member's family and caregivers as an integral part of the care team and provide education and community linkages to support their efforts.
- Encourage practitioners to communicate with not only the member with dementia, but also with his or her family and caregivers to facilitate the execution of the care plan.
- Encourage members with dementia and their families to participate in planning regarding advanced directives for health decisions as well as for financial and legal matters.
- Partner with local agencies serving older adults with dementia and their caregivers to assure that appropriate services are available in the community.

Depression

- Heighten awareness among both members and practitioners of the impact of depression on quality of life and on the management of other acute and chronic conditions.
- Regard older members with chronic illnesses and those receiving rehabilitation for conditions such as stroke and myocardial infarction as candidates for targeted screening.
- Support the development of evidence-based treatment programs that include:
  - Primary care teams (formal or informal) with expertise in diagnosing and treating depression in older adults.
  - Active monitoring of patients started on treatment.
  - Consultation from mental health specialists for patients who do not improve with treatments offered by the primary care team.
- Ensure that primary care practitioners have the tools, incentives and resources to facilitate identification and appropriate monitoring of older members with depression.
- Facilitate effective communication between primary care and mental health services. Whether mental health services are internal or external, managed care organizations should ensure that they:
  - Communicate with the primary care practitioner.
  - Offer expertise in geriatric psychiatry.
  - Prescribe medications that are accessible to members via the medication formulary.
  - Manage members across the care continuum.

Under-nutrition

- Educate practitioners regarding the central role of under-nutrition in chronic disease management and functional rehabilitation.
- Promote the evaluation of body weight as a routine vital sign taken at each medical encounter. Members who experience a weight loss of 10 pounds or greater over the past six months should receive further assessment.
- Ensure that nutritional status is a focus of care management and disease management programs.
- Encourage practitioners to evaluate older members for under-nutrition upon admission to hospital, subacute and home health care—since patients undergoing care transitions represent an under-recognized high-risk group.

- Establish linkages with community nutrition programs and work with practitioners to facilitate referrals.

Urinary Incontinence

- Seek to identify older members with urinary incontinence and initiate effective treatment.
- Offer an incontinence self-management program, led by an appropriately trained practitioner, for motivated and cognitively intact members suffering from urge or stress incontinence.
- Support primary care management of incontinence either by offering guided incontinence self-management programs or by establishing a partnership with a community-based agency that provides this service.
- Empower members to discuss their incontinence symptoms with their primary care practitioners.

APPENDIX 4

Recommendations from *One Patient, Many Places: Managing Health Care Transitions* (February 2004)

Some 23 percent of hospitalized patients over age 65 are discharged to another institution, and 11.6 percent are discharged with home health care. Not all patients undergoing transitions are at high risk for adverse events. However, those with poor transitional care plans are particularly likely to "fall through the cracks"—especially since patients transferred between sites may have a new diagnosis or a change in functional status that affects their ability for self-care.

The following recommendations are intended to enable managed care companies to improve the quality of care delivered to patients undergoing transitions.

Accountability

- Establish policies and procedures for members undergoing transitions and educate contract providers and facilities as to their content.
- Ensure that members undergoing care transitions have an identified and responsible practitioner at all times.
- Establish performance standards for care transitions and monitor performance against these standards.
- Contract only with practitioners and institutions that meet predefined standards.

- Forge collaborative relationships among providers to establish performance expectations and monitor quality.

Information Needs for Managing Patients in Transition

- Define the essential data elements needed to provide high-quality care to members who are transitioning across sites of care.
- Assure that the essential data elements are conveyed to the receiving practitioners in a timely and accurate manner.
- Develop and maintain user-friendly information systems that facilitate practitioners' ability to access necessary data elements and communicate with one another across the continuum of care.

Practitioner Skill Sets and Support System

- Improve practitioner knowledge of the services and settings available across the continuum of care to facilitate the best match between a patient's care needs and the care setting.
- Ensure that practitioners have support systems that facilitate providing treatment, information, durable medical equipment and other services during a patient's transition.
- Assure that practitioners incorporate patients' goals, preferences and functional status into both short- and long-range care plans.

Patient and Caregiver Preparation

- Identify patients likely to require care transitions in the near future and engage them and their caregivers in pre-transition planning.
- Provide patients and caregivers with the resources and tools that will enable them to participate in the formulation of their transition care plan.
- For patients facing imminent transitions, prepare them and their caregivers for their role in the transition as soon after the date of admission as possible for non-elective admissions and before admission for elective admissions.

Financial Incentives and Structural Issues

- Ensure that financial incentives among providers are aligned to promote:
  - High-quality care transitions.
  - The transmission of essential data elements to practitioners involved in a patient's care across different settings.
- Structure their delivery systems to promote seamless transitions across care settings.

- Review benefit coverage and limitations with members and/or practitioners prior to a transfer and explain to members what they should expect at the next care setting(s).

APPENDIX 5

Recommendations from "Essential Components of Geriatric Care Provided Through Health Maintenance Organizations," *Journal of the American Geriatrics Society,* 1998

The HMO Workgroup on Care Management identified the essential components of geriatric care in HMOs as:

- A systematic program for identifying HMO enrollees at high risk for adverse health outcomes.
- A geriatric case management program that serves high-risk enrollees in all settings—including clinic, home and institution—to promote functional independence, prevent functional decline, enhance quality of life and ensure the appropriate use of health services.
- Geriatric expertise for designing and administering geriatric programs and for consultation with primary care physicians, case managers and other providers.
- Facilitation of geriatric education and training for primary care physicians, case managers and other health professionals.
- Programs to educate frail or chronically ill enrollees and their caregivers in self-care.
- Mechanisms to identify and coordinate services to meet enrollees' social needs.
- Wellness programs designed to promote successful aging and healthy living.
- A management information system that makes data available to providers.
- A continuous quality improvement program that measures the ongoing performance of selected geriatric care processes and outcomes.

APPENDIX 6

Recommendations from *Risk Screening Medicare Members Revisited* (2000)

- Health plans should perform risk identification as a central component of population-based care for new and existing older members.
- Health plans should select self-report questionnaires and risk indices based upon their intended purpose and use, including identifying high-risk members and planning service delivery.

- Health plans should use rigorously developed, validated self-report questionnaires for identifying high-risk new members. The Pra™ (which measures the probability of repeat hospital admissions) and the Frailty Score (which measures the probability of long-term care needs) are two examples.
- "Risk identification should include a focus on identifying members with geriatric syndromes for which effective interventions are known." For example, effective interventions exist for physical activity, falls, depression, incontinence, high-risk medications and under-nutrition.
- Effective risk identification strategies for existing members include: provider referral, analysis of administrative data (encounter, lab, pharmacy, utilization) and member (or caregiver) self-referral.
- Managed care organizations need to assist primary care practitioners, a critically important source for risk identification, to ensure that members who are at high risk for adverse events or who have geriatric syndromes are recognized and referred for appropriate intervention.

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