Risk Stratification;
a CALCULATED approach to care
Learning Objectives:
Participation in this workshop will enable you to:
• Describe how other clinics are implementing risk stratification models.
• Explore benefits and considerations when implementing risk stratification.
• Collaboratively develop a proposal to pilot in a clinic or department.
AGENDA:

1:00   Welcome and Overview
1:10   Getting Acquainted
1:30   Panel Presentations
2:30   Break
2:45   Questions for the Panel
3:15   Networking/Putting It Into Practice
4:15   Wrap Up and Key Learnings
4:30   Adjourn
Getting Acquainted
Panel Presentations
Risk Stratification: An Innovative Approach to Care Management

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2019 MDH Learning Days Conference
Serving 2.74 million people in 300 communities across 252,215 square miles in nine states and four countries.

- 44 medical centers
- $4.4 billion in annual revenue
- 291 clinics
- 48 senior living facilities
- 179,598 Sanford Health Plan Members
- 1,360 physicians, 921 advance practice providers and 6,348 registered nurses delivering care in more than 80 specialty areas
- 28,334 employees

Each year, Sanford provides:
- 5.3 million outpatient and clinic visits
- 81,637 admissions
- 159,032 surgeries and procedures
- 9,465 births
- 214,236 emergency department visits
MDH Health Care Home

• Certified Health Care Home Clinics
  – 21 North Region
  – 20 South Region
  – Combine regions in April 2019

• 12 Large Metro Clinics

• 29 Small Regional Clinics
Risk Stratification

- Risk Stratification is defined as an ongoing process of assigning all patients in a practice a particular risk status – risk status is based on data reflecting vital health indicators, lifestyle and medical history of your adult or pediatric populations.

Stratifying risk helps to:
- Address specific population management challenges
- Match risk with levels of care
- Individualize treatment plans to lower risk and improve function
- Align the practice with value-based care approaches
What is the aim of Risk Stratification

• Identify patients who are most likely to benefit from care management
  – Self Management
  – Reduce unnecessary utilization
  – Improve Health Outcomes
Why – Risk Stratify

• Registries
  – Colorectal Cancer Screening
  – Mammography Screening
  – Hypertension
  – Depression
  – Asthma
  – Cardiovascular Disease
  – Cervical Cancer Screening

• Payer / ACO contract
• CMS Utilization data
• Huddle Sheets
  – Obesity
  – HTN suspect
  – Pre Diabetes
  – Asthma Suspect
  – Anxiety Suspect
Patient Centered Medical Home Alignment

**MDH**
- Access and Communication Standard
- Registry Standard
- Care Coordination
- Care Plan Standard
- Quality Improvement Standard

**CPC+**
- Access and Continuity
- Care Management
- Comprehensiveness and Coordination
- Patient and Caregiver Engagement
- Planned Care and Population Health
Risk Stratification Process

- Algorithm Based Criteria
- Clinical Intuition
<table>
<thead>
<tr>
<th>Algorithm</th>
<th>Clinical Intuition</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Categorize patients into risk levels</td>
<td>• Care Team to refine algorithm score</td>
</tr>
<tr>
<td>• Diagnoses / Cluster</td>
<td>– Social Needs</td>
</tr>
<tr>
<td>• Data</td>
<td>– Utilization</td>
</tr>
<tr>
<td>• Structured Fields in EMR</td>
<td>– Health Literacy</td>
</tr>
<tr>
<td>• Vendor - analytic software</td>
<td>– Activation</td>
</tr>
<tr>
<td>• Automated</td>
<td>– Caregiver Support</td>
</tr>
<tr>
<td></td>
<td>– Behavioral / Medical Needs</td>
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</tbody>
</table>
Criteria - Utilization

- Hospital Encounter in the past year
- ED Encounter in the past year
- No Show Office Visit
Lab Values / Screening Tools

- A1C
- Blood Pressure
- ASCVD Score
- GAD score
- PHQ 9 score
- ACT score
Diagnosis

- COPD
- Diabetes
- CHF
- Chronic Liver Disease
- Depression
- Chronic Kidney Disease
Other Criteria

- Age
- Smoking Status
- BMI

Look back period of one year
High Risk 5%
Medium Risk 20%
Low Risk 75%
| Patient Age       | 18-39 – 0 pts  
|                  | 40-64 – 1 pt  
|                  | 65+ - 2 pts    |
| Hospital Encounter in past year | 1 point for each admission in the past year – up to 3 points |
| ED Encounter in past year         | 1 point for each ED visit in the past year – up to 3 points |
| No Show Office Visit             | 1 point for each no show office visit in the past year – up to 3 points |
| A1C >/=9:                      | A1C 8-8.9: 1 point  
|                               | A1C >/=9: 2 point |
| BP >/= 140/90:                  | BP >/= 140/90: 1 point |
| Last GAD 7 >9:                  | Last GAD score 10-14: 1 point  
|                               | Last GAD >/= 15: 2 points |
| Last PHQ 9 >9:                  | Last PHQ 9 score 10-14: 1 point  
|                               | Last PHQ 9 score >/= 15: 2 points |
| BMI > 40:                      | BMI >40: 2 points  
|                               | BMI</= 18.5: 2 points |
| ASCVD Score > 7.5:              | ASCVD Score > 7.5: 1 point |
| ACT < 20:                      | ACT<20: 1 point |
| Dx of COPD                    | Dx of COPD: 1 point |
| Dx of Diabetes                | Dx of Diabetes: 1 point |
| Dx of CHF:                    | Dx of CHF: 1 point |
| Dx of Chronic Liver Disease:  | Dx of Chronic Liver Disease: 1 point |
| Dx of Depression:             | Dx of Major Depression or Dysthymia: 1 point |
| Dx CKD                        | Dx CKD: 1 point |
| Tobacco Use                  | Tobacco Use: 1 point (current smoker or smokeless) |

- **High Risk – 5%**
- **Medium Risk – 20%**
- **Low Risk – 75%**

**Data Analytics team analyzed the entire patient population based on the algorithm to define the populations**
<table>
<thead>
<tr>
<th>Next Pulm Appt</th>
<th>Risk Stratification Score</th>
<th>Risk Adj</th>
<th>Risk Stratification</th>
<th>Asthma Gap</th>
<th>CAD/IVD Gap</th>
<th>Diabetes Gap</th>
<th>st BMI and %ile</th>
<th>Num of IF</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/16/2019</td>
<td>17</td>
<td></td>
<td>17</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
<td>66.67 kg/m²</td>
<td>9</td>
</tr>
</tbody>
</table>

**Risk Stratification Score**

The patient’s Risk Stratification Score

Note: External data might be a factor in metrics not marked with (a)

**Points Metrics**

1. Age: 56  
2. Hospital admissions: 9  
3. ED visits: 31  
2. No Show Apps: 2  
0. Systolic BP: 122  
0. Diastolic BP: 80  
2. BMI: 66.67  
0. Last smokeless tobacco use status: Never Used  
Smoking status: Never Smoker  
0. Hemoglobin A1c: 5.9  
1. Last GAD-7: 12  
1. Last PHQ-9: 11  
1. Asthma Control Test Score: 13  
0. ASCVD 10-Year Risk Score: 5.5  
0. Has chronic kidney disease: No  
1. Has congestive heart failure: Yes  
0. Has Chronic Liver Disease: No  
1. Has chronic obstructive pulmonary disease: Yes  
1. Has depression: Yes  
0. Has diabetes: No
GOAL
Self Management
Care Management Program

- Support patient self-management and activation.
- Awareness of community resources and social support.
- Coordination of care transitions and follow up.
- Coordinate closely with the care team, including Primary Care Practitioner, Integrated Health Therapist, Pharmacy, Social Worker and Specialty providers.
- Receive and review timely information on hospital and emergency department admissions.
- Motivational Interviewing / Goal Setting
Care Management

- Risk Stratification
- Longitudinal Care Management
  - Individualized Plan of Care
- Episodic Care management
  - Post hospital discharge
  - ED Follow up
  - Transitions in care
Future Enhancements – Criteria:

- Look back period – increase
- Utilization
- Poly Pharmacy
- Pediatric criteria
- CKD, CAD, CHF, Depression
- Social Determinants of Health
Future Enhancements – Criteria

Risk Stratification Score

The patient’s Risk Stratification Score

SDOH
Social Determinants of Health

- Alcohol: Risk Score: Not on file
- Daily Stress Risk Score: Not on file
- Depression Risk: Not on file

- Alcohol: Frequency: Not on file
- Alcohol: Standard Drinks Per Day: Not on file
- Alcohol: Binge Drinking: Not on file
- Daily Stress: Not on file
- Last PHQ-2 Score: Not on file
- Financial Resource Strain: Not on file
- Food Insecurity: Worry: Not on file
- Food Insecurity: Inability to Purchase: Not on file
- Intimate Partner Violence: Emotional Abuse: Not on file
- Intimate Partner Violence: Fear of Partner: Not on file
- Intimate Partner Violence: Physical Abuse: Not on file
- Intimate Partner Violence: Forced Sexual Contact: Not on file
- Physical Activity: Days Per Week: Not on file
- Physical Activity: Minutes Per Session: Not on file
- Social Connections: Religious Services Attendance Frequency: Not on file
- Social Connections: Socialization Frequency: Not on file
- Social Connections: Club Membership: Not on file
- Social Connections: Living with Spouse or Partner: Not on file
- Transportation Needs: Medical: Not on file
- Transportation Needs: Non-medical: Not on file
References


THANK YOU!
Risk Stratification from a Rural Perspective
Our Mission: Our passion and purpose is to strengthen and nurture the health and well-being of our family, friends, neighbors and communities, through every season of life.

Our Vision: We will be Central Minnesota’s preferred health system, regionally recognized for innovative, cost effective and high quality care while focusing on the health and well-being of those living in the communities we serve.
Our Values:

Integrity
Because patients trust us with their lives.

Compassion
Because we serve people in their most vulnerable moments.

Excellence
Because lives are at stake.

Hospitality
Because everyone is welcome here.

Accountability
Because we take our responsibility to heart.
Core Team

Risk stratification involves all members of the organizational team. While key players may involve a physician champion, quality or population health staff, and administrative personnel, the work of Risk Stratification and implementation of new policies, workflows, and procedures could not be done without considering the frontline staff and ancillary workers.

“Change is more difficult when it’s coming from the people who are not familiar with the work. The people who do the work have the best ideas, and that’s an important concept not only to understand and absorb as a quality person, but to instill in the team as well.” – Alyssa Palmer, Southside Community Health Services, Director of Quality
The Journey
Alexandria Clinic and HCH

- Initial certification
- PrimeWest and the Accountable Rural Community Health (ARCH) agreement
- Horizon Public Health collaboration with PW and the Alexandria Clinic to develop workflows based on mutual goals
Initial Efforts at Risk Stratification

- Received registry data from PrimeWest
- Care Coordinators made phone calls to patients based on their identified gaps in care
- A clinic level approach was focused on addressing the needs of the Medicaid population
- Workflow was done by the care coordinators
Progression

• As the Quality Team continued to grow, risk stratification efforts grew as well
• New partnerships with more payors allowed for increased access to data
• Culture change from a focused approach on specific populations led to a clinic-wide change
• Risk stratification strategies were applied to the entire population and embraced by team members at all levels
Partnerships and Data
ACOs and Community Partnerships

- ARCH agreement with PrimeWest Health
- Central Minnesota Health Network
- Insurance agreements with Humana and BCBS
- Horizon Public Health Partnership
- Long term care (SNF)
- Controlled Substance Care Team and Community Task Force
Risk Stratification: Primary Prevention

- Best practice in cost reduction and quality of care
- Reports and data from partnerships guide workflows to address gaps in care
- Creativity and continuous improvement to identify what works and what doesn’t
Examples
Hospitalizations/ED Use

- LPN Quality Team member works daily reports for hospitalizations and ED use
- Sends notifications (telephone encounters in Epic) to nursing team members for follow up
- Standard “dot phrase” used to ensure consistent follow up is done
- Informal screening for care coordination done with each chart review by Quality Team member
Transitional Care Workflow Example
Hospitalizations and ED Use
Colorectal Cancer Screening

Our records show you are due for your colon cancer screening.

Here are your options:
☐ FIT Test (Stool Test)– Done yearly
☐ Colonoscopy -- Done approximately every 10 years
☐ Other tests available—Discuss with your Physician or Provider

Have you had one of these tests completed at another facility? If yes, where?

______________________________________________________________________

Do you have questions regarding colorectal cancer screening?
☐ Yes
☐ No
Next Visit Begins Today

Next Visit for:

Check out notes entered
Print After Visit Summary

Follow up for _______ with _______
in: _____ days  _____ weeks  _____ months  3 months  6 months  1 year  Other _______
Follow up for _______ with _______
in: _____ days  _____ weeks  _____ months  3 months  6 months  1 year  Other _______

Labs
Please circle: Fasting or Non-fasting

Labs today (orders entered)

Future appointment lab orders:

- Basic Metabolic Panel LAB027704
- Complete Blood Count LAB0231761
- Comprehensive Panel LAB027670
- Creatinine LAB020374
- Glucose LAB020469
- Hemoglobin LAB020446
- Hemoglobin A1C LAB0202531

Hepatic Function Panel LAB027688
Lipid Panel LAB023273
Screening PSA LAB027050
TSH LAB0248849
Urinalysis LAB0210683
Urine Dipstick with Reflex to Micro LAB027001
Urine Microalbumin LAB0255166

Other- please specify: ____________________________

Imaging

Imaging today (orders entered)

Future appointment orders:

- Mammogram
- EKG
- Dexa Scan
- Chest x-ray

Other- please specify: ____________________________

Here for Life
Risk Stratification Hospital Readmissions

• Quality team member runs monthly report of hospital readmissions and gives to HCH Coordinator (Care Coordination lead at Alomere Health)
• HCH Coordinator reviews chart for:
  • Frequency of hospitalizations/ED visits
  • Extensive diagnoses/Chronic Conditions
  • Polypharmacy
  • High risk diagnoses**
  • Frequency of PCP office visits
• Suggests care coordination consideration to PCP and Care Coordination Team
• Once enrolled in CC, MDH Tier Tool is used to further risk stratify
• Information is put into patient’s active problem list to indicate their tier # and if they have external care plans
Where Do You Go From Here?
Types of Risk Stratifying

- Advance Directives
- Medicare Annual Wellness Visits
- Well-Child Visits
- Mammogram Completion
- Colorectal Screening
- Diabetic Optimal Care Measures
- Mental Health (Anxiety and Depression)
- Hypertension
- COPD
- Controlled Substance Use
What do you do with this data?

• Utilize Functionality in your EHR to run lists/build reports
• Use care team members
• Try different approaches
• Remember—it’s what you do with this information that matters
Thank you!
Break
Questions for the Panel
Networking/Putting It Into Practice
Wrap Up and Key Learnings
Adjourn
Thank You!