

**Welcome to Minnesota Department of Health
Health Care Homes Webinar**

**Risky Business: One Health Care System's
Model of Risk Stratification**

The webinar will begin momentarily.

Risky Business: One Health Care System's Model of Risk Stratification

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Presenter



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Disclosure Statement:

None of the planners nor the presenters have any relevant financial relationships or conflicts of interest to disclose

Learning Objectives

- Identify key components to stratify your patient population
- Provide examples of how your healthcare organization can implement care management strategies to support your high risk and complex patient population

SANFORD HEALTH TODAY

Serving over 3 million people in 300 communities across 252,215 square miles in nine states and nine countries.

 44 medical centers

 \$6.1 billion in annual revenue

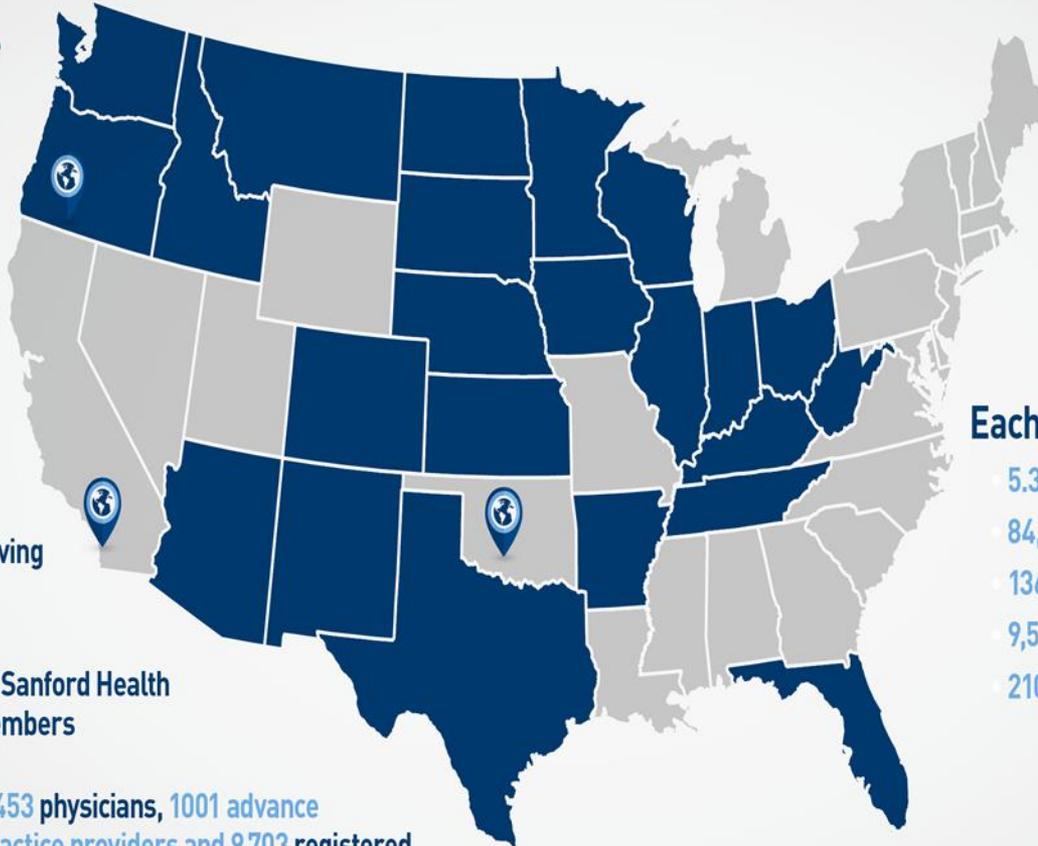
 482 clinics

 242 senior living facilities

 188,574 Sanford Health Plan Members

 1,453 physicians, 1001 advance practice providers and 9,703 registered nurses delivering care in more than 80 specialty areas

 48,622 employees



Each year, Sanford provides:

- 5.3 million outpatient and clinic visits
- 84,466 admissions
- 136,436 surgeries and procedures
- 9,537 births
- 210,129 emergency department visits

 Health Service Delivery Area

 World Clinics

Risk Stratification



What is the aim of Risk Stratification

- Identify patients that will benefit from Care Management
- Improve health outcomes
- Reduce harm and waste
- Reduce unnecessary utilization

Why Risk Stratify

- Population Health
 - actionable view into the needs of your patient population
 - target care management resources more effectively

Why?

Patient Centered Medical Home Alignment

- Joint Commission
- Minnesota Department of Health – Health Care Home
- South Dakota Medicaid Health Home
- Compass Practice Transformation Network
- Comprehensive Primary Care Plus (CPC+)

Data Sources

- 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

Risk Stratification Process

- Algorithm Based Criteria
- Clinical Intuition



Algorithm

- Defined Criteria
- Categorize patients into risk levels
- Diagnoses / Cluster
- Claims data
- Structured Fields in EMR
- Vendor - analytic software
- Automated – Key!

Clinical Intuition

- Care Team may modify the risk score
 - Social Needs
 - Utilization
 - Health Literacy
 - Activation
 - Caregiver Support
 - Behavioral / Medical Needs



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
- Generalized Anxiety Disorder (GAD)
- Patient Health Questionnaire (PHQ 9)
- Asthma Control Test score



Diagnosis

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

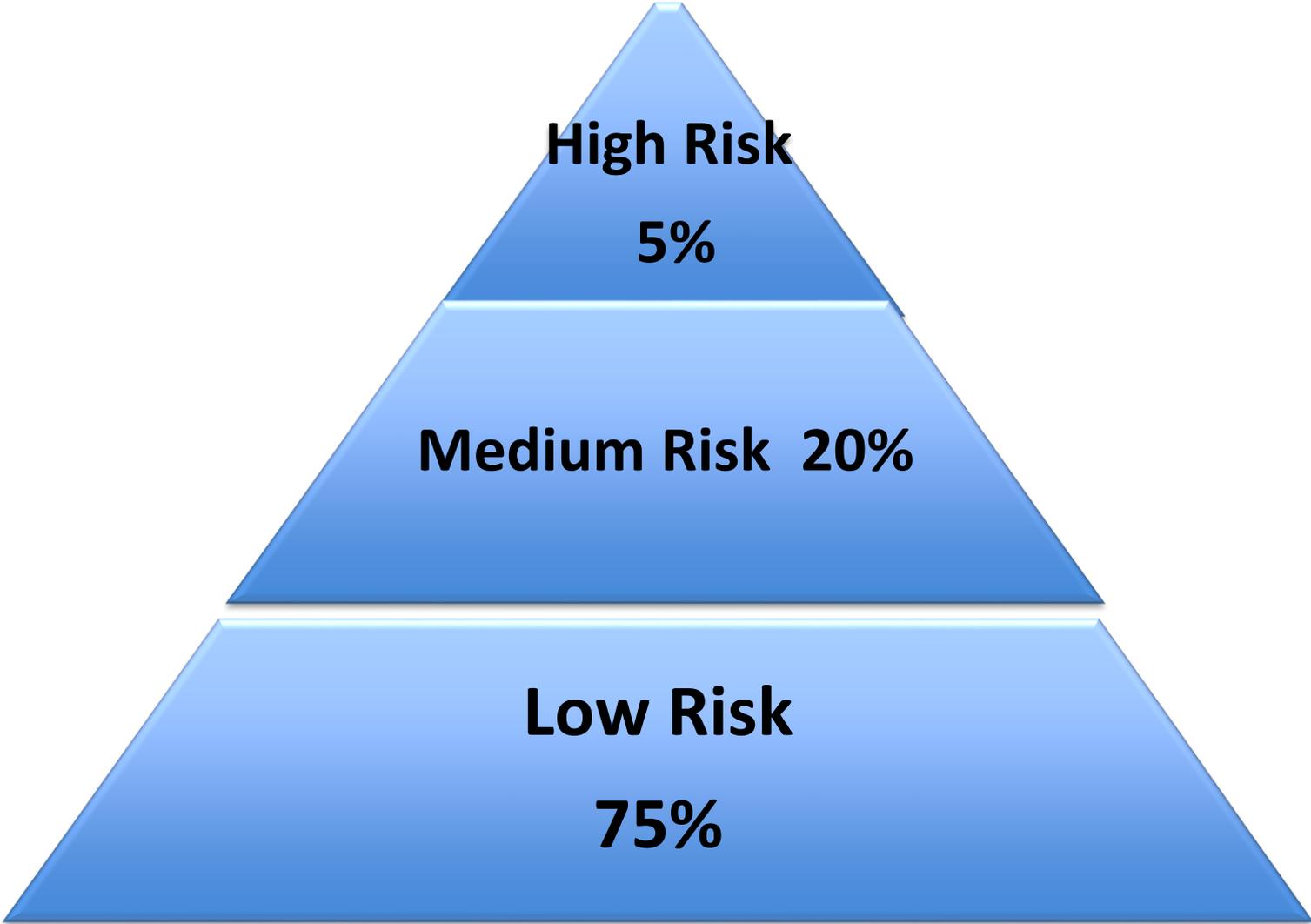


Other Criteria

- Age
- Smoking Status
- BMI



Look back period of one year



17

17

Risk Stratification Score

The patient's Risk Stratification Score

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

Points Metrics

- 1 Age: 56
- 3 Hospital admissions: 9
- 3 ED visits: 31
- 2 No-Show Appts: 2
- 0 Systolic BP: 122
- 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**

17

16

Care Management

GOAL

Self Management

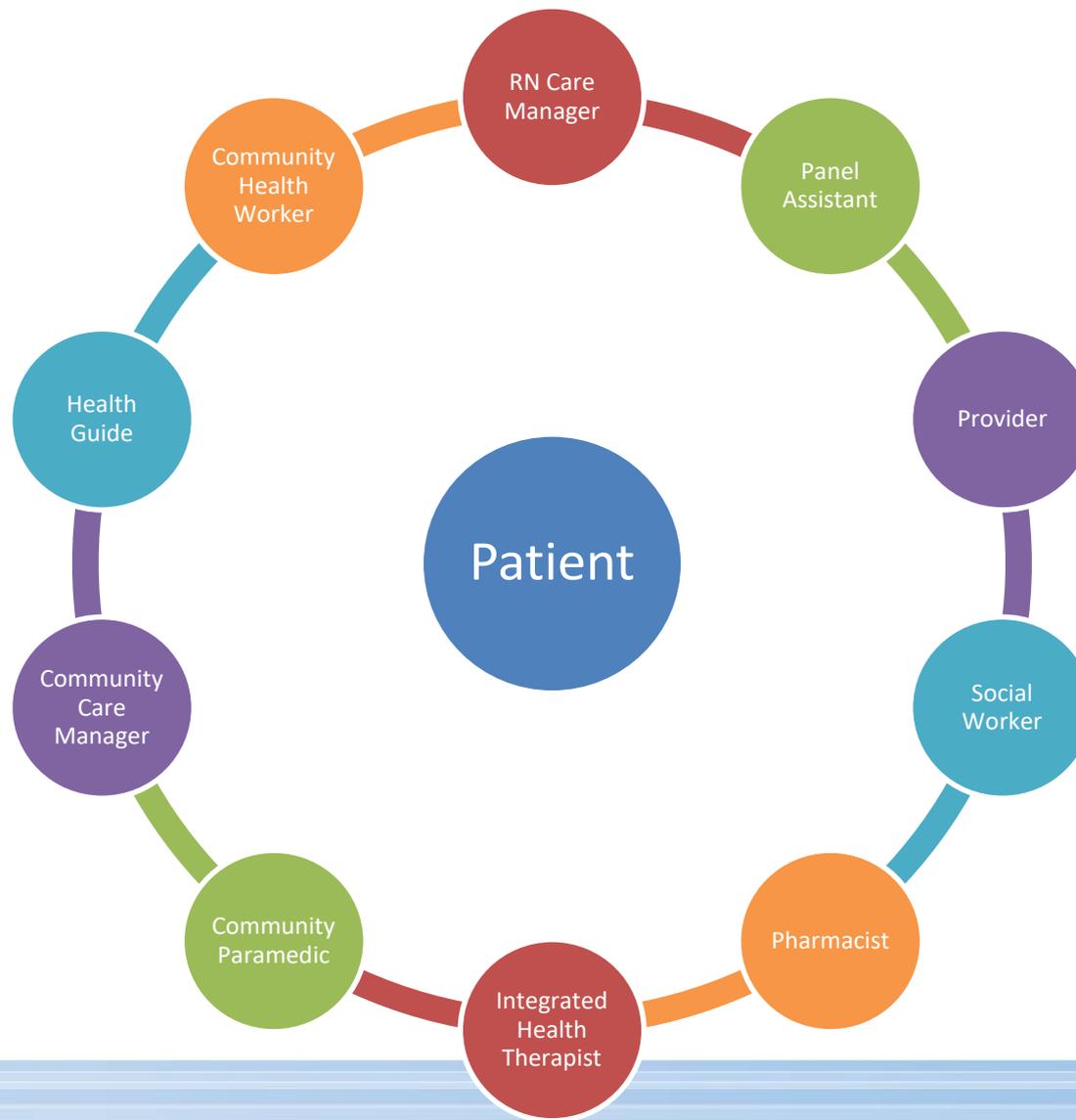
Care Management

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



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
- Receive and review timely information on hospital and emergency department admissions
- Motivational Interviewing / Goal Setting



Low Risk Panel

- Panel Assistant / Care Team Associate
 - Chronic Disease registries
 - Wellness registries
 - Defined Workflows
 - Patient Outreach



Medium Risk Panel

- Front line nursing staff
 - Preventative Health Needs
 - Patient Education
 - After Visit Summary
 - Daily Huddle

BMI Gap Card

- BMI <18.5 or > 25
- BMI not on problem list
- No documented follow up plan
 - .bmiplan
 - Education
 - Referral
 - Goal
 - Weight loss encounter/appointment
 - Enrollment –adult weight loss program
 - Only if BMI >27

Diabetes Gap:

- A1C greater than 8 or not done in past year
- Statin therapy or no Lipid panel in past year
- Elevated Blood pressure
- Smoker or Smokeless tobacco use
- No Aspirin use or anti-coagulation therapy, or no documented Aspirin allergy

High Risk Panel

- RN Care Managers
- Care Team
 - Licensed Social Worker
 - Integrated Health Therapist
 - Community RN Care Manager
 - ED Care Managers
 - Community Health Worker
 - Pharmacist

Daily Team Huddle

- Huddle Sheet
- Schedule
 - Add risk score to clinic schedule

Last Weight: 199.30 08/24/2015		Last Height: 70.984 06/23/2015		BP Goal:	
Colonoscopy		FIT		Lung Screen	
Colonoscopy 11/11/2009				Overdue 06/26/2000	
Overdue 11/11/2014					
Tobacco: Current Some Day Smoker		Smokeless: Never Used			
Essential hypertension					
Blood Pressure		HTN Protocol Meds & Other Antihypertensive			
164 / 88 08/24/2015		HYDROCHLOROTHIAZIDE 25 MG PO TABS			
162 / 92 08/24/2015		LOSARTAN POTASSIUM PO			
139 / 87 06/23/2015					
Type II or unspecified type diabetes mellitus without mention of complication, not stated as uncontrolled					
Coronary atherosclerosis					
Tobacco Use		Blood Pressure		Medication	
Tobacco: Current Some Day Smoker		164 / 88 08/24/2015		Statin: SIMVASTATIN 80 MG PO TABS	
Smokeless: Never Used		162 / 92 08/24/2015		Last LDL: 62 06/18/2015	
		139 / 87 06/23/2015		QC ADULT ASPIRIN LOW STRENGTH PO	
				HGB A1C	
				10.7 06/19/2015	
				0.0	
				0.0	
				Non-MNCDM Patient Info	
				No HM DM eye exam	
				No HM DM foot exam	
				MICROALBUMIN/CREATININE RATIO 178 06/18/2015	
Other and unspecified hyperlipidemia					
06/18/2015					
Cholesterol 113		Cholesterol		Cholesterol	
Triglyceride 69		Triglyceride		Triglyceride	
HDL 37		HDL		HDL	
LDL 62		LDL		LDL	

High Risk Assessment Team



High Risk Assessment Team

- Care Team Members
 - RN Community Care Manager
 - Clinic Social Worker
 - RN Ambulatory Care Manager
 - Integrated Health Therapist
- Meet weekly to review high risk patients
- Criteria for choosing the patients

High Risk Assessment Team

- Each team member reviews the patients prior to the weekly meeting.
- The high risk patient is presented as a case study
 - Demographics
 - Risk Score
 - PCP
 - Upcoming appointment at primary care clinic
 - Utilization report
- Care coordination with the patient's community teams

High Risk Assessment Team

- Each month review
 - previous patients
 - current health status
 - action plan completed
 - ongoing needs
- Our team continues to evaluate the effectiveness of this process
- Are we improving the health outcomes of the patient?

Risk Stratification

Future Enhancements - Criteria

- Look back period – increase
- Utilization
- Poly Pharmacy
- Chronic Conditions
- Pediatric criteria
- Social Determinants of Health

Future Enhancements - Criteria

Risk Stratification Score

The patient's Risk Stratification Score

Points	Metrics
1	Age: 54
0	Hospital Admissions: 0
0	ED Visits: 0
0	No-Show Appts: 0
0	Systolic BP: 126
0	Diastolic BP: 76
0	BMI: Not on file
1	Smoking Tobacco Use Status: Current Every Day Smoker
	Smokeless Tobacco Use Status: Never Used
0	Hemoglobin A1c: Not on file
0	Last GAD-7: Not on file
0	Last PHQ-9: Not on file
0	Asthma Control Test Score: Not on file
0	ASCVD 10-Year Risk Score: Not on file
0	Has chronic kidney disease: No
0	Has Congestive Heart Failure: No
0	Has Chronic Liver Disease: No
0	Has Chronic Obstructive Pulmonary Disease: No
0	Has Depression: No
0	Has Diabetes: No
0	Alcohol: Risk Score: Not on file
0	Daily Stress Risk Score: Not on file
0	Depression Risk: Not on file

SDOH

Social Determinants of Health

Points	Metrics
?	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 Connects: Club Meeting Attendance 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

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Questions



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