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
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
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

- EMR Registries
- Payer / ACO contract
- CMS Utilization data
- Daily Huddle Sheets
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
High Risk
5%

Medium Risk  20%

Low Risk
75%
Risk Stratification Score
The patient's Risk Stratification Score

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
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
Patient

- RN Care Manager
- Panel Assistant
- Provider
- Social Worker
- Pharmacist
- Integrated Health Therapist
- Community Health Worker
- Health Guide
- Community Care Manager
- Community Paramedic
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
  - Add risk score to clinic schedule
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 Action Plan

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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: 2
- Metrics:
  1. Age: 54
  2. Hospital Admissions: 0
  3. ED Visits: 0
  4. No-Show Appts: 0
  5. Systolic BP: 126
  6. Diastolic BP: 76
  7. BMI: Not on file
  8. Smoking Tobacco Use Status: Current Every Day Smoker
  9. Smokeless Tobacco Use Status: Never Used
  10. Hemoglobin A1c: Not on file
  11. Last GAD-7: Not on file
  12. Last PHQ-9: Not on file
  13. Asthma Control Test Score: Not on file
  14. ASCVD 10-Year Risk Score: Not on file
  15. Has chronic kidney disease: No
  16. Has Congestive Heart Failure: No
  17. Has Chronic Liver Disease: No
  18. Has Chronic Obstructive Pulmonary Disease: No
  19. Has Depression: No
  20. Has Diabetes: No

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

SDOH: Social Determinants of Health

- Points: 0
- Metrics:
  1. Alcohol: Frequency: Not on file
  2. Alcohol: Standard Drinks Per Day: Not on file
  3. Alcohol: Binge Drinking: Not on file
  4. Daily Stress: Not on file
  5. Last PHQ-2 Score: Not on file
  7. Food Insecurity: Worry: Not on file
  8. Food Insecurity: Inability to Purchase: Not on file
  10. Intimate Partner Violence: Fear of Partner: Not on file
  11. Intimate Partner Violence: Physical Abuse: Not on file
  12. Intimate Partner Violence: Forced Sexual Contact: Not on file
  13. Physical Activity: Days Per Week: Not on file
  14. Physical Activity: Minutes Per Session: Not on file
  17. Social Connections: Club Meeting Attendance Frequency: Not on file
  18. Social Connections: Club Membership: Not on file
  19. Social Connections: Living with Spouse or Partner: Not on file
  20. Transportation Needs: Medical: Not on file
References

Questions
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THANK YOU!