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Risk Stratification—
CPC Practice Strategies

April 9, 2014

Moderator

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Introductory Comments

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Risk Stratification-
CPC Practice Strategies

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What Is Risk Stratified Care Management and Care Coordination?

A systematic, reliable and organized way to get **patients** what they need… when they need it.

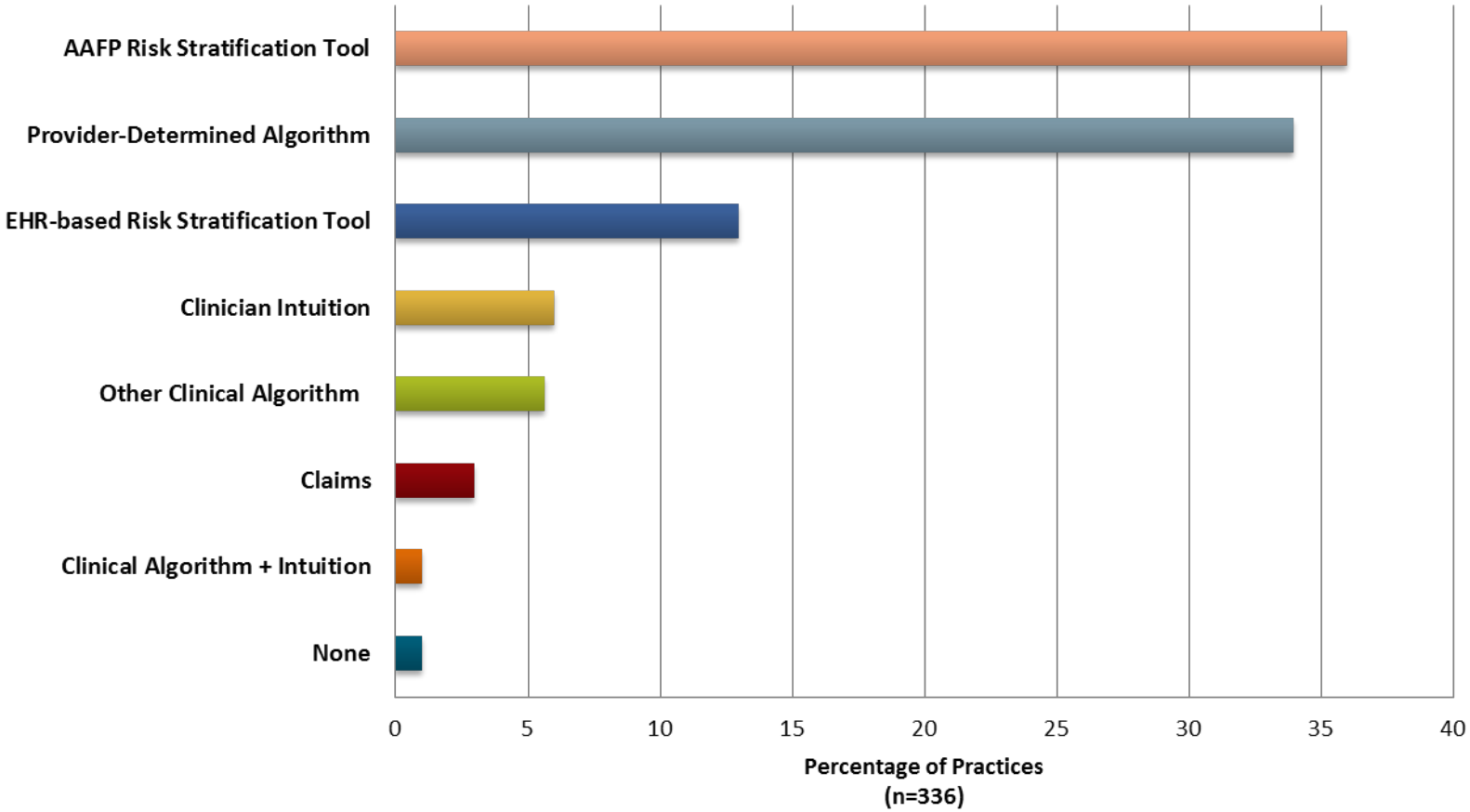
Today's Conversation

- Progress to date from CPC practices
- Review the "Why" for RSCM
- Review conceptual framework
- What do you need to do this well?
- Work flow considerations
- Care management strategies
- Measures of success

All CPC Practices Should Have:

- An explicit RSCM strategy
- A well defined risk assignment algorithm
- Assigned clear roles and responsibilities to support RSCM
- A registry function to manage RSCM effort and support the team approach

Risk Stratification Types



Risk Stratification Themes

1) A vast majority of practices are actively using and implementing risk stratification to guide care management

2) About 1/2 use existing risk stratification tools currently available (AAFP algorithm & EHR-based tools)

3) About 1/3 developed own algorithm based on input from their providers

4) A lot of experimentation occurring about how to best track risk – registries and/or tagging within EHR?

RSCM Strategy is Part of Overall Population Health Management

- A defined group of patients at the practice level who would benefit from a common approach
- Could be disease specific or group with special needs such as high risk or complex care
- Requires resources and an organized approach
- Data driven…use information systems to support this work

A Patient's Care *and* Patients' Quality

- Our training and traditional conduct of care has been to focus on the individual
- Population management requires a systematic approach to all the patients with the condition
- Quality assessment and measures of adherence to EB Guidelines can only be done in the aggregate

Why Is RS-CM and CC Important?

- Identify patients who need the most help…
  - Managing their chronic conditions (CM)
  - Navigating the medical neighborhood (CC)
- High leverage for managing costs
- Supports evidenced based and timely care
- Keeps people from “falling through the cracks” in our fragmented system

Risk Stratification Guide

This guide reflects on how CPC practices across the country have approached the risk stratification component of Milestone 2. Anticipated release date is mid-April

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An Initiative of the Center for Medicare & Medicaid Innovation

Risk Stratification: A Study of CPC Practice Approaches

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Risk-Stratified Care Management and Coordination

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Table 1: Examples of Potentially Significant Risk Factors

Clinical Diagnoses, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization/Claims Data	Clinician Input (Personal Knowledge)
– Any chronic disease, particularly one that is not in control or at desired goal – Chronic pain – Substance abuse (alcohol/drug/tobacco) – Terminal illness – Advanced age with frailty – Multiple co-morbidities – Pre-term delivery of newborn – Child, youth, or adult with special needs – Anxiety, schizophrenia, bipolar, depression, or other behavior affecting health – Dental health – Dementia/Alzheimer's disease	– Non-ambulatory – Needs Assistance with Activities of Daily Living (ADLs) – Severely diminished functional status – Declining eyesight – Extreme weakness or fatigue – At risk for falls	– Lack of financial or family support that impacts care – Unemployed – No health insurance – Low health literacy – Unsafe home environment – Homeless – Lives alone and needs assistance with ADLs – Transportation for health care appointments is difficult – Language barriers	– Frequent hospitalizations (particularly heart failure, GI disorders, and pneumonia) – Frequent office, ER, or urgent care visits – Multiple providers – Hospital readmission within 30 days – Major procedure in last year – Chronic kidney disease – Brain trauma – Expensive medications	– Polypharmacy – Patient is taking several medications that may not all be needed and/or could have potential for interactions – High-risk medications – Non-compliant with treatment plan – Confusion with medications or following the treatment plan – Recent move to long-term facility or other transition of care – Spouse (who was the caregiver) recently deceased – Lack of engagement in care plan – Low confidence or ability for self-management – Answer to the question: Is this patient at higher risk for dying within the next year?

Table 2: Risk Categories and Levels using Diabetes Example Case

CATEGORY	PRIMARY PREVENTION (Low Resource Use) GOAL: To prevent onset of disease		SECONDARY PREVENTION (Moderate Resource Use) GOAL: To treat a disease and avoid serious complications		TERTIARY (High Resource Use) GOAL: To treat the late or final stages of a disease and minimize disability	CATASTROPHIC/COMPLEX (Extremely High Resource Use) GOAL: May range from restoring health to only providing comfort care
Stage	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**Level 6**
	No known diagnoses or complex treatments	No known diagnoses but demonstrates warning signs or potentially significant risk factors	Has diagnosis, but stabilized or in control; potentially significant risk factors	Has diagnosis and/or complex treatment, and at higher risk for complications or potentially significant risk factors	Has diagnosis, complex treatment, and complications or potentially significant risk factors– goal is to prevent further complications	• Very severe illness or condition and potentially significant risk factors • End-of-life care • Premature baby (May have high costs with limited or no opportunity for improvement, stabilization, or cost control)
Example of using uncontrolled progression of diabetes	• Healthy	• Blood glucose and lipids rising, but still within desired parameters • BMI elevated • Smoker	• Diagnosed with type 2 diabetes, blood sugar, and lipids brought within desired parameters • Married, family involved	• Blood sugar and lipids not within desired parameters, and financial situation impacting negatively • Lives alone • One ER visit and one hospitalization	• Has diabetes with early renal disease, coronary artery disease, failing eyesight, and lives alone • Three ER visits and two hospitalizations in past year • Dual eligible Medicaid/Medicare • Needs Assistance with Activities of Daily Living (ADLs)	• Diagnosed with lung cancer • Recent myocardial infarction • Progression to ESRD with renal dialysis • Amputation of one leg • Blind • Lives in nursing home

A Conceptual Framework For RSCM (PDF)

American Academy of Family Physicians

www.aafp.org/rscm

How Many Categories Should We Have?

- Enough to segment the patient panel to determine specific strategies
- Most find that three or four is minimum
- Categories should have **clinical relevance** that helps determine the strategy
- Focus on **high risk/high need patients** first then fill in the needed features for those with less risk or primarily requiring wellness and prevention

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Risk Categories from CPC Practices

SCHOOL OF COMMUNITY MEDICINE

Risk Stratification Methodology

Risk Scores & Stratum

The patient risk stratification methodology applies to the following clinics: Family Medicine, Internal Medicine, Pediatrics, and Community Health. Three types of risk scores will exist in Pentaho and/or the EMR: System-Calculated, Provider-Identified, and Payer-Identified. The following risk stratums will be used:

Stratum	System-Calculated	Provider-Identified	Payer-Identified
High	X	X	Medicare & BCBS
Med-High	X	X	Medicare & BCBS
Med-Low	X	X	Medicare & BCBS
Low	X	X	Medicare & BCBS

Calculated Risk Score

Each patient will received a numeric risk score based on the matrix. The numeric score will be converted into a risk stratum (above).

Indicator	Definition	Risk Points	Risk Points Criteria
Age	Age of member	0 1	> 18 months & < 65, >= 65; <= 18 months
Hospital Admissions	Hospital admissions, last 12 months, any reason	0 1 2	0 admissions, 1-4 admissions, > 4 admissions
ER visits	ER visits , last 12 months, any reason	0 1 2	0 ER visits, 1-5 ER visits, > 5 ER visits
Prescriptions	Number of active prescribed medications	1 2 3	1-5 prescriptions, 6-10 prescriptions > 10 prescriptions
Chronic Diseases	Chronic disease diagnoses, last 2 years: diabetes, cardiovascular disease*, asthma, COPD, cancer, HIV, hepatitis C, chronic pain**, bipolar, and schizophrenia	0 1 2	0 diagnoses, 1-3 diagnoses, > 3 diagnoses

*cardiovascular disease = CAD, CHF, cerebrovascular and PAD

**chronic pain = Chronic pain syndrome, Chronic low back pain, Chronic back pain, Chronic neck pain, Fibromyalgia, Neuropathy

Mercy Pediatric Risk Stratification Tool

Mercy Pediatric Risk Stratification Tool

Risk Level:
Patient Name: Evaluated by:
Age: DOB:
Risk Stratification Level: Score

Evaluation Date:
Provider:
Last Evaluation Date:
Last Risk Level:

BIRTH TO 18 YEARS

CARE PLANNING	Risk 1: 0-1	Risk 2: 2-3	Risk 3: 4-6	Risk 4: 7-9	Risk 5: 10-13	Risk 6: 14-18
SCORE	LOW 0		MODERATE 1		HIGH	EXTREMELY HIGH 2
1 AGE	3 years to 18 years		Birth to 35 months		Premature (<36wks) - 12 months	SCORE
2 HOSPITALIZATIONS (last 12 months)	0 TO 1		2		3 OR MORE	
3 ER VISITS (last 12 months)	0 TO 1		2		3 OR MORE	
4 ALL OFFICE VISITS (last 12 months)	Birth to 23 months: 4-5 visits 2 years to 18 years: 1-2 visits		Birth to 23 months: 2-3 or 6-7 visits 2 years to 18 years: 3-4 visits		Birth to 23 months: 1 visit or >8 visits 2 years to 18 years: >5 visits	
5 CURRENT PRESCRIPTION MEDICATIONS	No Medications		1-2 medications		3 or MORE Oxygen Use	
6 Family/Caregiver LANGUAGE/HEALTH LITERACY	• Primary language: English • Carry's out plan of care well • Demonstrates understating of health care needs • Independently seeks health information		• Limited English: verbal skills • Hearing impaired • Carries out some of the plan of care • Requires some reinforcement		• Requires interpreter for all practice interactions • Not able to carry out plan of care without continued reinforcement • Requires routine reinforcement and education	
7 CHRONIC DISEASE (does not include mental health dx)	• No chronic disease • Non Smoker/no secondhand smoke • Growth chart: Between the 25th and 75th percentile		• 1 chronic diseases diagnosis • Exposure to secondhand smoke • Growth Chart: <25th percentile or >75th percentile		• 2 or more chronic disease diagnoses • Tobacco use • Growth chart: <10th percentile or >85th percentile	
8 CHRONIC DISEASE QUALIFIER	• N/A		• 1 or more chronic disease diagnoses uncontrolled		• 1 or more chronic disease diagnoses, severely uncontrolled	
9 Family/Caregiver/Patient MENTAL & BEHAVIORAL HEALTH (Includes but not limited to dementias, substance abuse, autistic disorders, eating disorders, developmental delays, depression, ADD, ADHD, etc.)	• No Mental Health diagnoses		• 1 Mental health diagnosis • Routine follow up with provider and or mental health provider • 1-2 significant life stressors (divorced parents, young parents <20, single parent, unemployment)		• 2 or more mental health diagnoses • 3 or more significant life stressors (divorced parents, young parents <20, single parent unemployment)	
MENTAL & BEHAVIORAL HEALTH QUALIFIER	• N/A		• 1 or more Mental Health diagnoses uncontrolled		• 1 or more Mental Health diagnoses severely uncontrolled	
10 Family/Caregiver/Patient SOCIAL DETERMINATION OF SELF-MANAGEMENT	• Steady income • Stable residence • Adequate medical insurance • Meets basic ADL's		• Receives some support to meet social needs • Some medical insurance • Meets some of basic ADLs		• Homeless • Unsafe home environment • Unemployed • Lack of financial or family support that impacts care • Transportation barrier • No medical insurance	

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Risk Categories from CPC Practices

Grand Lake PRIMARY CARE
YOUR PARTNER IN HEALTH

Risk Stratification Protocol for Staff

LOW	MEDIUM	HIGH
No problems. Minimal problems.	Controlled: HTN, Hyperlipidemia. Diabetes A1c less than 7 Allergies Asthma Low ER or Hospital utilizer. Psychiatric Issues Cancers in remission.	CHF COPD DIABETES: A1c greater than 7 CANCER DEMENTIA High ER/Hospital Utilizer Poor social support HIGH MORTALITY RISK
Preventive Care	Preventive Care Medication Compliance Checks Specialty Referrals if needed Home Management Education Diabetes Ed Classes	Preventive Care Medication Compliance Checks Specialty Referrals if Needed Home Health? Or Hospice? Weekly Phone calls/Monthly vis Home Management Education Family/caregiver Engagement Home Visits?

Adopted Renee J Russell, MD, INC, PC 1/23/2013

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Risk Stratification Process

Level I: Primary Prevention — **Low Resource Use**

Goal: To Prevent onset of disease

1. No known diagnosis or complex treatments
2. Healthy
3. Demonstrates warning signs of potentially significant risk factors

Strategies for Level I

- Preventive screenings and immunizations, lifestyle counseling, internet resources, patient engagement, motivational interviewing, lifestyle changes for weight loss, exercise and healthy diet.

Level II: Secondary Prevention — **Moderate Resource Use**

Goal: To treat disease and avoid serious complications

1. Has diagnosis but stabilized or in control; potentially significant risk factors
2. Have diagnosis and/or complex treatment and at higher risk for complications or potentially significant risk factors.

Strategies for Level II

- Strategies for Level I plus encouragement and support, home monitoring, family/care giver engagement, engage community resources, support groups, sub-specialty **referrals** as necessary, in person and online training, health coach, care plan

Level III: Tertiary Prevention — **High Resource Use**

Goal: To treat the late or final stages of a disease and minimize disability

1. Has diagnosis, complex treatment, and complications or potentially significant risk factors. Goal is to prevent further complications.

Strategies for Level III

- Strategies for Level I and II plus intensive care management plan with assigned responsibility to a clinically trained team member, regular follow up and contact between visits, tracking ER visits, secondary sub-specialty referrals and hospitalizations.

Level IV: Catastrophic /Complex — **Extremely High Resource Use**

Goal: May range from restoring health to only providing comfort care

1. Very severe illness or condition and potentially significant risk factors
2. End of life care
3. Premature baby
4. May have high cost with limited or no opportunity for improvement, stabilization or cost control

Strategies for Level IV

- Strategies for Level I, II and III plus customized care plan, end of life planning, palliative care, hospice, intensive family / caregiver engagement and support.

It takes a team

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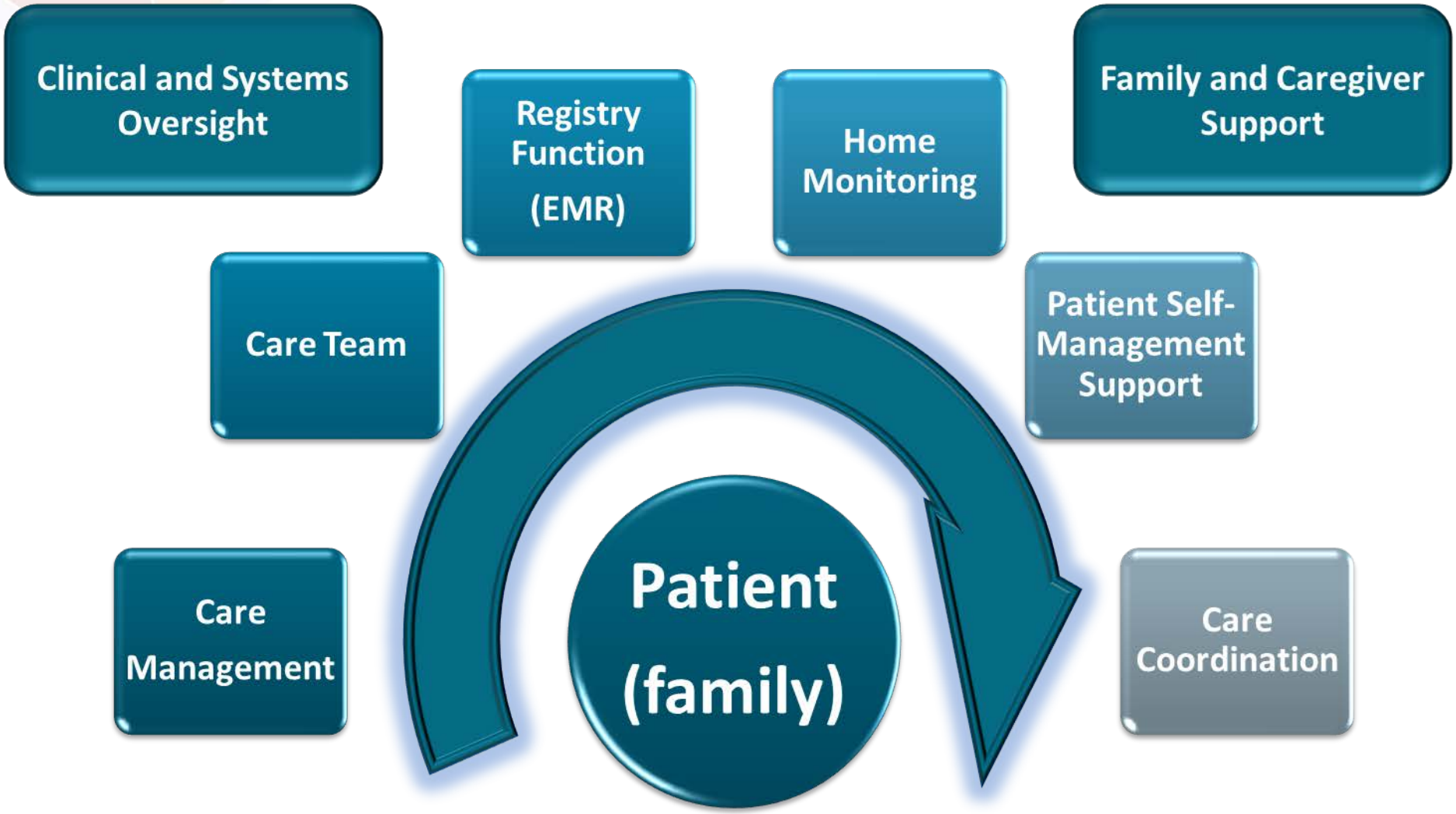

Important Components of RS-CM and CC

- Identify the high risk group (top 5% to 7%)
- Develop a care plan for each patient
- Use a registry function to support tracking and outreach
- Match resources to patient specific needs
- Use the entire care team
- Measure success

You Already Know What You Need To Do RS-CM and CC Well

- An algorithm for assigning risk
- A game plan for each risk category
- A system to keep track of patients in high risk categories (EMR field and registry)
- Staff assigned to monitor and for outreach
- Care coordination across the medical neighborhood

How Is That Working For You?

Workflow Considerations

- What staff are responsible for making the initial category designation?
- When does it occur?
  - Empanelment, Pre-visit, at check-in, rooming, clinician
- Who can change the category up or down?
- Who has final determination?
- What do you do for every high risk patient as they leave the office? (e.g. appointments, follow up, outreach, home visit set up)

Three Things To Keep In Mind

- Milestone 2 goal is 95% of patients empaneled and 75% of those risk stratified
- The precision with which you assign patients to a category is not as important as what you do for them once they are assigned
- With time this process will become part of the normal work flow and more intuitive

Progress Check

- Can we identify the top 5% to 7% of patients who really need the help to improve care, reduce harm and where the high leverage in terms of cost savings will be?
- Are the interventions with these patients effective?
- What is our ongoing approach to refining the effort? (QI strategy and metrics)

Training For The Care Team

- Discuss roles and responsibilities
- Keep in mind that care management and care coordination are functions and not necessarily an FTE
- In a small practice, this work may only take a few hours per week
- Consider sending a staff member for formal training
- Cross train all staff in appropriate features of care management and care coordination

Recognize Special Circumstances

- Cognitive impairment
- Poly-pharmacy
- Social isolation
- Mobility issues
- Vision and hearing impairment

Do you have a systematic approach to these issues?

Considering Palliative and Hospice Care

- Delicate issue because some will presume it is about cost cutting
- There may be a time when just increasing the intensity of the same stuff may not be helpful
- Consider it an opportunity to ramp up a different kind of support
- Family engagement is critical
- Sometimes there may be no effective interventions

They Are Already Familiar But Are You Missing Anyone?

- Think about the patients who need RSCM most…they will be in the office one or more times in a short period.
- Do you have a way to identify patients attributed to your practice that have not been in lately?
- Let anyone on the care team add someone to the list of high risk using criteria with or without provider sign off depending on your protocol

Registry Function For High Risk Is Essential

- Helps track patient progress
- Identifies gaps in care
- Calls attention to patients who need more help
- Helps you know how you are doing for all patients with this level of risk
- Supports the team approach to care and outreach
- Makes the care more efficient and more effective

Practice Stories

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- Medical Director, Robert Wood Johnson Medical Group
- Associate Professor,
- Department of Family Medicine and Community Health

Tracie Koepplin

- *Clinical Manager*
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RSCM Checklist

- ❑ We have an explicit **algorithm** to assign risk scores
- ❑ R**isk scores** are recorded in a **searchable field** in EMR or on the problem list
- ❑ We have an explicit **strategy** or approach for each risk level
- ❑ We use a **registry function** to track and manage the high risk patients
- ❑ We designate a **team member** to take overall responsibility for keeping the system organized and current
- ❑ Our entire **care team** has been trained on the essential features of RSCM and how to use the system
- ❑ We are getting regular feedback from staff and patients to constantly improve our RSCM system

What Are We Missing?

- If you cannot identify the top 5% to 7% of patients in terms of cost and/or need, you need a new system
- The precision with which you determine the risk score is not as important as your strategy for those in the category
- An Individualized Care Plan is essential

Measures Of Success

- Keep track of **quality measures** to demonstrate improved performance
- Percentage of all patients with a **risk score recorded**
- Percentage of high risk patients with a **care plan** on the chart
- **ER visits** per year in the high risk groups (ER Visits/1000)
- Hospital **bed days per thousand** (commercial and Medicare)
- Total **cost of care** in the practice (per member per month)
- Percentage of patients called, seen in office or home within **72 Hours of discharge** from hospital or ED visit

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The Ultimate Measure- "The Three-Part Aim"

- **Better individual care**
  - Quality of care-clinical performance measures
  - Satisfaction with the experience of care
- **Better population health**
  - Defined population within the practice
  - Ability to aggregate individuals for quality assessment
- **Lower per capita cost of care**
  - Total cost of care on a PMPM basis
  - Proxies such as ER utilization, bed days/1000, ALOS

Conclusions

- Risk-stratified care management and care coordination makes good **clinical sense**
- RSCM engages the entire **team** in the care of the most difficult patients
- A systematic approach gets better results for **patients** and fuels professional satisfaction because we know we are doing a better job

~~If We Build It…They Will Come" –Field of Dreams~~

**"If We Build It With Them…
They Will Already Be There"**

-Christine Bechtel

National Partnership for Women and Families

Milestone 4- Patient Experience

Questions

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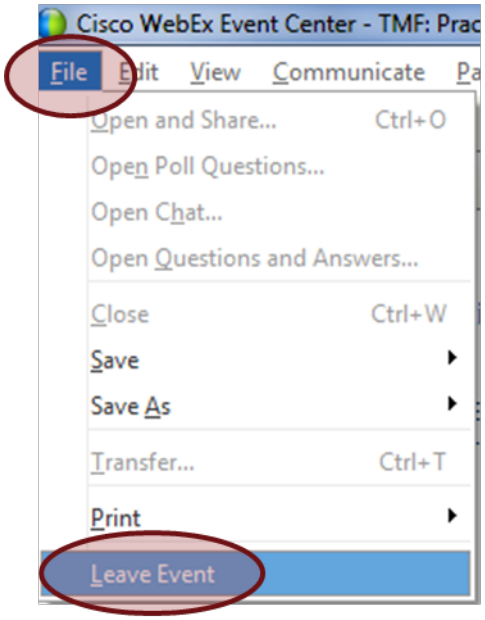
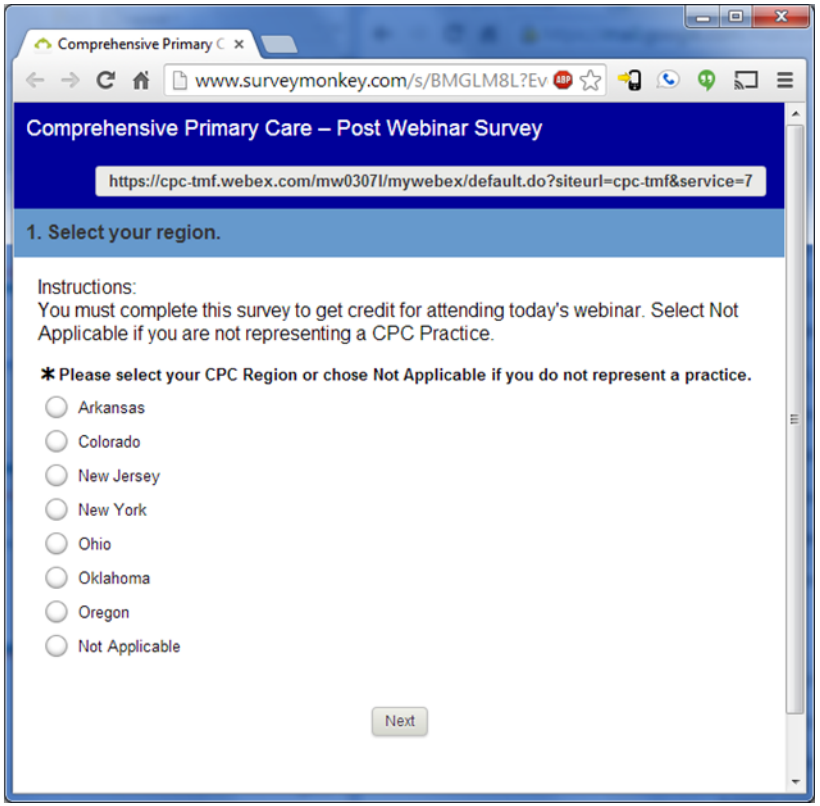
What Is Next?

- April 24 (Noon ET): National Open Mic
- May 7 (1 p.m. ET): Medication Management
- May 13 (2 p.m. ET): Behavioral Health Integration with Virtual Site Visits
- May 15 (12-12:30 ET): National Open Mic
- May 27 (Noon ET): Self-Management Support with Virtual Site Visits

Post Event Attendance & Feedback