Risk Stratifications

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IHH LEARNING COLLABORATIVE

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Please consider completing this pre-test while we wait.
Link: https://www.surveymonkey.com/r/riskstrat-pre

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Defining Risk Stratification

- “Risk stratification is a technique for systematically categorizing patients based on their health status and other factors” – American Academy of Family Physicians
- “Identifies patients with certain risks and how that affects your population health strategy” – Johns Hopkins
- “Risk stratification enables providers to identify the right level of care and services for distinct subgroups of patients. It is the process of assigning a risk status to patients, then using this information to direct care and improve overall health outcomes.” – National Association of Community Health Centers
- Health care delivery model and tool intended to improve member outcomes and reduce cost by analyzing data, comorbidity, and multifaceted factors

CMS Involvement

- Created and funded the Medicaid Innovation Accelerator Program
- Main goal of “targeting” and “tailoring” efforts to combat increased need for care and associated costs
- How do we best use our resources?
  - Prevent negative health outcomes
  - Improve health outcomes overall
- Includes Macro and Micro initiatives
  - Macro: state level – how do we distribute funds?
  - Micro: individual level – meeting individual needs

Risk Stratification Activities

Precise analytics using data from the past can help to calculate the probable future impact of certain interventions on utilization, cost of care, health status and quality of life. There are a variety of risk stratification activities that can be employed to accomplish this. Understanding the potential value of each activity is an important first step in the process of determining an approach to risk stratification and subsequent targeting. Two common risk stratification activities are described below. These activities are not mutually exclusive, and state Medicaid agencies may use one or both throughout the life cycle of a BCN state initiative.

- **Tiering:** This activity supports the establishment of risk levels and thresholds within a hierarchical structure, and the assignment of beneficiaries to distinct risk levels/categories based on multiple factors including, but not limited to case complexity and costs, level of "impactability" and levels of interventions required to mitigate risk.
- **Predictive Modeling:** This activity applies statistical techniques, learnings from controlled studies and the analysis of complex data to attribute a level of risk to a beneficiary and, perhaps of more value, infer the probability that a beneficiary's risk level might increase or decrease depending on certain factors.

IHH SPA

- Utilize member-level information, profiles, and care coordination plans for high-risk individuals.
- Incorporate tools and evidence-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers.
- Conduct interventions as indicated based on the member's level of risk.
- At least monthly reporting of member gaps in care and predicted risks based on medical and behavioral claims data matched to Standard of Care Guidelines.

IHH SPA continued...

- Promoting members' health and ensuring that all personal health goals are included in person-centered care management plans.
- Assess the member's social environment so that the care plan incorporates needs, strengths, preferences, and risk factors.
- Assessing member's readiness for self-management using screenings and assessments with standardized tools.
- Creation of a person-centered care plan by a licensed health care professional with the member and individuals chosen by the member that addresses the whole person's needs with input from the interdisciplinary team and other key providers.

Iowa Administrative Code continued

Assessment of the member's social environment → The plan of care incorporates areas of needs, strengths, preferences, and risk factors, and the below:

Comprehensive care management.

The initial and ongoing assessment and care management services aimed at the integration of primary, behavioral, and specialty health care, and community support services, using a comprehensive person-centered care plan or service plan that addresses all clinical and nonclinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

Care coordination.

Includes assisting members with medication adherence, appointments, referral scheduling, understanding of health insurance coverage, reminders, transition of care, wellness education, health support, lifestyle modification, and behavior changes.

- The health home must work with providers to coordinate, direct, and ensure results are communicated back to the health home.

Iowa Administrative Code continued

Health promotion.	The education and engagement of a member in making decisions that promote health management, improved disease outcomes, disease prevention, safety, and an overall healthy lifestyle.
Comprehensive transitional care.	The facilitation of services for the member that provides support when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community-based group home, family, self-care, or another health home).
Individual and family support.	Communication with the member and the member's family and caregivers to maintain and promote quality of life, with a particular focus on community living options. Support will be provided in a culturally appropriate manner.
Referral to community and social support services.	Coordinating or providing recovery services and social health services available in the community, including resources for understanding eligibility for various health care programs, disability benefits, and identifying housing programs.

Provider Manual

- The Health Home shall:
  - utilize member-level information, member profiles, and care coordination plans for high-risk individuals.
  - Incorporate tools and evidence-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers.
  - Conduct interventions as indicated based on the member's level of risk.

IOWA HHS

Provider and Chapter

Integrated Health Home Program

Chapter III. Provider-Specific Policies

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Referral and Related Activities

The IHH shall assist, as needed, the member in obtaining needed services, such as by scheduling appointments for the member and by connecting the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the person-centered service plan.

Provider Manual

2. Expected Outcome of Service

- Improved care coordination will be noted through chart reviews, claims, and analysis
- Strengthened community linkages noted through administrative review, chart reviews and claims
- Strengthened team-based care noted through administrative review
- Increased integration of primary and behavioral health care noted through administrative review
- Improved health outcomes noted through analysis
- Improved health status noted through analysis
- Reduction in hospitalizations noted through analysis
- Reduction in hospital readmissions noted through analysis
- Increased access to primary care, with a reduction in inappropriate use of emergency room noted through analysis
- Improved identification of substance use/abuse and engagement in treatment noted through analysis
- Reduction in lifestyle-related risk factors noted through analysis
- Improved experience of care noted through analysis

Purpose – The "Why"

Preventative efforts

- Identifying need or potential need for intervention
- Targeted support provided BEFORE to a crisis; reduction in ER/IP visits

Operationalized processes

- Developed protocol based on tiers
- Clear policies within organizations on how to allocate efforts

Encouragement of self-management

- Supporting member with individual needs
- Providing members with resources based on risk factors and score

Efficient collaboration

- Coordination between all members of care team
- Unduplicated efforts amongst IHH team

Using a Risk Strat Tool

Step 1

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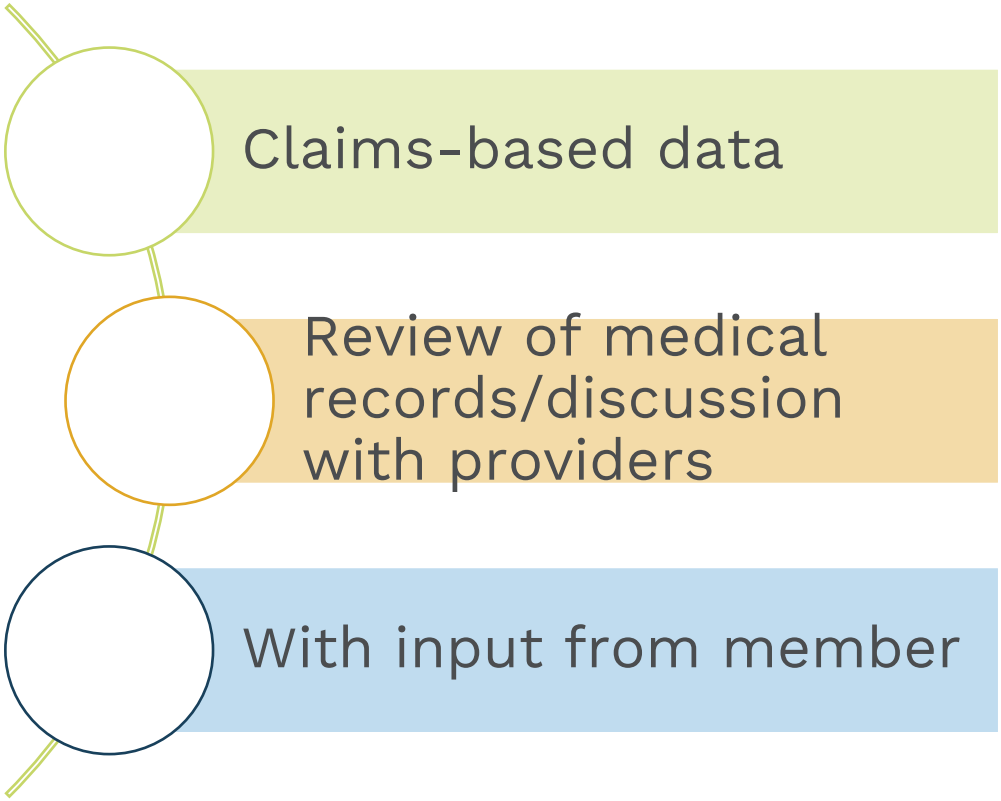
How To use the Risk Strat Tool

Any of these methods an be used alone or in combination to *complete* the risk stratification.



Potential Topics

Physical and mental health diagnoses

Substance use and abuse history

Social drivers of health

History of falls

Suicide attempts or thoughts of self-harm

Inpatient and ER visit history

Income and housing

Scoring

Scoring and tiering is up to each IHH

- There is no standardized template required.
- Printable templates are free or for purchase, or can create your own

Example

- Member has access to transportation
  - 3: No access to transportation
  - 2: Some access to transportation
  - 1: Complete access to transportation
- Transportation
  - 1: Needs assistance
  - 0: No assistance needed

Develop your tiers/classifications

- Green, yellow, red
- Low, medium, high
- 1, 2, 3, 4, 5

Screener Vs. Stratification?

- Risk stratification is not intended to replace other screeners, questionnaires, or tool
  - There are benefits of specific assessments
- Comprehensive snapshot of members to inform next steps and care efforts
- Tiering and classification based on scoring sets the stratification apart from a screener
- Results are intended to be applied and used for preventative care and overall health

Applying Risk Strat Results to Member Care

Step 2

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Taking the Next Step

Results are intended to inform member care, and coordination, and create actionable follow-up.

What to consider:

- Develop an internal protocol based on results
- Incorporate other members of the interdisciplinary team as appropriate
- Discuss results with members and support them in making appointments, accessing services, and obtaining resources as needed
- Develop a process for follow-up after support is provided to determine efficacy

Using Results

- Identifying risks and potential for risk is only one piece of the puzzle
- Risk strats will be most useful alongside policies and procedures corresponding with tiers, which each IHH can develop
  - Low: routine communication/follow up
  - Medium: additional call from CC/peer support/NCM, sharing specific resources, making referrals
  - High: interdisciplinary team meeting
- Think “How do I use this information?” or “What can I do with these results?” after completing the risk strat.

Considerations

- What does your IHH team look like?
  - How many of each role do you have?
  - What are their caseloads/capacity?
- How many members do you serve?
- Balancing standardized efforts with individualized care
  - Maintaining a protocol for each tier without compromising member-specific care
- Evaluate if the protocols are impactful, or if changes should be made
  - Use data from quarterly reports, missed appointments, ER/IP utilization rates

Questions

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