**Core Objectives**

- Horizon BCBSNJ - Innovative Care & Payment Programs
- Risk stratification
  - Goals
  - Considerations
  - Available tools/resources
- Examples

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**Using Risk Stratification to Help Achieve the Triple Aim**

**June 20, 2013**

NJ Academy of Family Physicians

*Advanced Topics in Healthcare Delivery: Ensuring a Viable Practice Using Patient-Centered Approach*

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**Core Objectives**

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**What is Risk Stratification?**

- A systematic process for identifying and predicting patient risk levels relating to health care needs, services, and coordination
- Goal is to identify those at the highest risk or likely to be at high-risk and prioritizing the management of their care to prevent poor health outcomes
- Allows practice to maximize use of limited time and resources to prioritize needs of their patient population
- Involves use of algorithms and registries, payer data, physician/provider judgment/input, and patient self-assessments and experiences

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**Transforming NJ’s Healthcare Delivery System**

- Through collaboration, we are helping to create an effective, efficient and affordable delivery system
- Patient-Centered Medical Home Program (PCMH) - 700 physicians benefiting over 200,000 members
- Participating in Comprehensive Primary Care (CPC) Initiative
- Accountable Care Organization (ACO) – launched three ACOs in NJ
- Episode of Care Program for Hip and Knee Joint Replacement

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**Horizon’s Innovative Programs / Continued Expansion in 2013**

- Patient-Centered Medical Home Program
- Accountable Care Organization
- Episode of Care Program

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**Formalizing Risk Stratification**

- Risk stratification is a relatively new term for something that physicians have done for years
  - Identifying those patients that have the highest risk
  - If monitoring, management and care is not provided patients will fall through the cracks
  - Making sure patients get what they need when they need it
- Formalizes practice transformation and medical home concepts by putting a structured process in place
  - Physician drives engaging entire care team and practice technologies
Three Goals for Risk Stratification

1. Forecast patient’s health risks
2. Prioritize interventions
3. Mitigate adverse outcomes (e.g., disability, mortality, unnecessary costs)

Steps to Consider

• Identify and implement a simple process or algorithm that is easily understood
  ➢ Examples of categories include:
    1. Risk level
    2. Definitions
    3. Criteria
    4. Limitations

• Develop a team or process that will assign risk score for each patient

• Record in electronic health record (EHR) system or registry, database, etc.

Steps to Consider (cont.)

• Determine and deploy process for updating - i.e. at each visit, after significant events (hospitalization, ER visit, transition to specialist, etc.)
  ➢ Designate team member(s) responsible for keeping system organized and current

• Assign staff member to monitor process and algorithm to ensure it’s being used correctly, updated according to process, etc.

• Provide feedback to physicians, providers, and care team regarding:
  ➢ Process/changes needed
  ➢ Opportunities for improvements
  ➢ Success stories

What works best for your practice?

• Patient population has extremely varying needs

• Individual patient needs will change over time

• Additional factors to consider: age, co-morbidities, mental health, poverty, social challenges, inability to self-manage, “frequent flyers,” high cost, any combination of the above

• No one one-size-fits all approach – need to identify what will work best in your practice

• For example, what works for your patient population:
  ➢ High, medium, low categories; six stratification levels; four stratification groups, etc.
  ➢ Stratify as patients are seen; stratify patient population based on empanelment; stratify based on recent event (hospitalization, etc.)

Risk Stratification: A Means for Predictive Modeling

“Predictive modeling is a set of tools used to stratify a population according to its risk of nearly any outcome...ideally, patients are risk-stratified to identify opportunities for intervention before the occurrence of adverse outcomes that result in increased medical costs.”


Where Can I Get Tools?

• Information payers provide for patients

• Health risk assessments

• Maybe included in EHR system

• Patient Activation Measures (22 or 13 question set)

• American Academy of Family Physicians - Risk-Stratified Care Management and Coordination

• Purchase predicative modeling tool

• Create your own
Combining payer claims-based risk scores and information with clinical risk assessment helps practices to better identify and focus on high-risk patients.

### Horizon’s PCMH Care Management Report

| LAST_NAME | Patient Last Name | FIRST_NAME | Patient First Name | RISK_SCORE | Patient’s latest risk score | AGE | Patient’s Age | GENDER | Patient’s gender | ER | Count of ER visits year to date | IP | Count of IP Admits per year to date | PCP | Count of visits to the Medical Home per year to date | LAST_VISIT | Date of last visit to the Medical Home | PRIMARY_RISK | Patient’s primary condition | SECONDARY_RISK | Patient’s secondary condition | DX1 | Clinical quality measure eligible denominator count. | DX2 | Clinical quality measure eligible denominator count. | DX3 | Clinical quality measure eligible denominator count. | PRODUCT | Commercial or Medicare Advantage | LTM_COST | Total costs for care in the last 12 months. |
|------------|------------------|------------|--------------------|------------|-----------------------------|-----|----------------|--------|------------------|----|---------------------|-----|-----------------------------|-----|-----------------------------|-------|-----------------------------|-----------|--------------------------------|----------|--------------------------------|----------|--------------------------------|----------|--------------------------------|---------|--------------------------------|

### Risk Stratification – Practice Example

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

**Goal:** To prevent onset of disease

- No known diagnosis or complex treatments
  - Healthy
  - Demonstrates understanding of 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

- Has diagnosis but stabilized or in control; potentially significant risk factors
- 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/caregiver 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

- 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

- Very severe illness or condition and potentially significant risk factors
- End of life care
- Premature baby
- 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.

### Risk Stratification: Questions to Get Started

- Use one or two of these questions to get started:
  - **Who would you not be surprised to hear was admitted to the hospital in the next six months?**
  - **Who would you not be surprised to hear passed away in the upcoming 12 months?**

- These are the patients who are most likely to be considered highest risk and can benefit from tracking, care management and outreach/education

### Key Takeaways

- Risk stratification is a purposeful, planned and proactive process developed and deployed in the practice to coordinate and plan for patient’s needs, care, and services
- Risk stratification should not end with creating a patient list – it should be used to develop and define roles and responsibilities for proactively caring and managing the varied patient populations within the practice