Risk Stratification & Care Coordination

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Agenda

- Overview and Goals of Risk Stratification and Care Coordination
- Our risk tool and data
- SDOH
- Lessons learned using PDSA
- Care Coordination
- Next Steps and Beyond
Why are we interested in risk stratification?

What if we could intervene in patients before they needed emergency care? What would that look like, and what would the impact be?
What do we want to accomplish

Specifically- What do we want to accomplish with this project?

- Stratify patient population into 6 cohorts
- Identify patients that have complex care needs
- For those that have complex care needs, create care plans
  - Self-management goals
  - Goals for preventative and chronic illness
  - Action plan for flare ups
How do we know when we are successful?

What is the measurement of success? How do we know when this project has been completed?

- Risk scores that have been vetted by our clinical staff
- Documented workflows that promote team-based care
- Will be tracking patient risk over time to see impact of work
- Communication/Implementation Plan
- On-going improvement plan
What is our approach

Explore → Engage → Examine → Execute → Ensure Excellence

Explore
- Plan
- Act
- Study

Engage
- Plan
- Do

Examine
- Plan
- Act
- Do
- Study

Execute
- Plan
- Act
- Do
- Study

Ensure Excellence
- Plan
- Act
- Do

LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL
Is this Project Relevant?

Population Segmentation
Data from May'17 to May'18 (13 months). Note: This data will not be updated monthly

Select Plan Attributes

Select Region and Clinic Attributes

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Plan Attributes</th>
<th>Region Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Markets</td>
<td>Jackson Care Connect</td>
<td>Jackson</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Jackson Care Connect</td>
<td>Jackson</td>
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<tr>
<td>Medicare</td>
<td>Jackson Care Connect</td>
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<tr>
<td>Medicaid</td>
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<tr>
<td>United States</td>
<td>Jackson Care Connect</td>
<td>Jackson</td>
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</tbody>
</table>

Total
6,669 members (100%)
$21M paid (100%)

Healthy
5,058 members (76%)
$5M paid (23%)

Low Risk
656 members (10%)
$2M paid (100%)

Rising Risk
897 members (13%)
$10M paid (49%)

High Risk
58 members (1%)
$4M paid (19%)

Data provided by Jackson Care Connect. This is not our risk stratification tool, but there is a strong correlation.

- United States has the most costly healthcare system in the world.
- Risk Stratification combined with care coordination is an approach that could
  - Improve our patient population’s health
  - Improve experience of care
  - Reduce healthcare cost
Risk Stratification

Cohorts

Is the patient healthy with no chronic disease, or significant risk factors?

Is the patient healthy, but at risk for chronic disease, or significant risk factors?

Does the patient have one or more chronic diseases, with significant risk factors, but is stable or at desired treatment goals?

Does the patient have one or more chronic diseases with significant risk factors, and is unstable or not at treatment goals?

Does the patient have multiple chronic diseases, and significant risk factors, complications, and/or complex treatments?

Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?
# Risk Stratification Calculation

<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th>Mental Health</th>
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<tbody>
<tr>
<td>Substance Abuse Disorders</td>
<td>Social Determinates of Health</td>
</tr>
<tr>
<td>Pain</td>
<td>Clinic Utilization</td>
</tr>
<tr>
<td>Appointment Adherence</td>
<td>Personal Behaviors</td>
</tr>
</tbody>
</table>

- Depression
- Mal-nutrition
- Heart Failure
- HIV
- Alcohol Addiction
- Bi-Polar
- Smoking
- Rheumatoid Arthritis
- Appt. adherence
- Housing Constraints
- Hep C
- Abuse
- Chronic Pain
- Diabetes
- Cancer
- Cancer
- Diabetes
- Chronic Pain
- Appt. adherence
- Housing Constraints
- Hep C
- Smoking
- Rheumatoid Arthritis
- Bi-Polar
- Alcohol Addiction
- HIV
- Heart Failure
- Mal-nutrition
- Depression

Risk factors and medical conditions are cross-referenced with mental health and social determinants to calculate risk stratification.
Prevalent Risk Indicators

Risk by Category

<table>
<thead>
<tr>
<th>Detail</th>
<th>Central Point</th>
<th>Family Health Care Center</th>
<th>Wellness Center</th>
<th>West Medford</th>
<th>Grand Total</th>
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</thead>
<tbody>
<tr>
<td>Non-Adherence</td>
<td>523</td>
<td>779</td>
<td>987</td>
<td>862</td>
<td>864</td>
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<tr>
<td>Obesity</td>
<td>192</td>
<td>777</td>
<td>1,062</td>
<td>932</td>
<td>657</td>
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<tr>
<td>Hypertension</td>
<td>197</td>
<td>902</td>
<td>1,070</td>
<td>589</td>
<td>639</td>
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<tr>
<td>Anxiety</td>
<td>366</td>
<td>630</td>
<td>768</td>
<td>598</td>
<td>518</td>
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<tr>
<td>Nicotine</td>
<td>337</td>
<td>592</td>
<td>660</td>
<td>442</td>
<td>574</td>
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<tr>
<td>Respiratory Disease</td>
<td>195</td>
<td>520</td>
<td>597</td>
<td>415</td>
<td>387</td>
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<td>SUD</td>
<td>455</td>
<td>350</td>
<td>520</td>
<td>265</td>
<td>318</td>
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<tr>
<td>Diabetes</td>
<td>89</td>
<td>393</td>
<td>547</td>
<td>518</td>
<td>336</td>
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<tr>
<td>Chronic Pain</td>
<td>148</td>
<td>337</td>
<td>301</td>
<td>359</td>
<td>286</td>
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<tr>
<td>Circulatory system</td>
<td>66</td>
<td>309</td>
<td>345</td>
<td>193</td>
<td>189</td>
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<tr>
<td>Other mental health disorder</td>
<td>130</td>
<td>217</td>
<td>257</td>
<td>187</td>
<td>180</td>
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<td>PTSD</td>
<td>147</td>
<td>164</td>
<td>182</td>
<td>171</td>
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<tr>
<td>Bipolar</td>
<td>173</td>
<td>122</td>
<td>167</td>
<td>138</td>
<td>123</td>
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<tr>
<td>Complex Care</td>
<td>45</td>
<td>165</td>
<td>188</td>
<td>97</td>
<td>158</td>
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<tr>
<td>SDOH</td>
<td>86</td>
<td>105</td>
<td>145</td>
<td>150</td>
<td>101</td>
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<tr>
<td>Cancer</td>
<td>24</td>
<td>157</td>
<td>174</td>
<td>92</td>
<td>105</td>
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<tr>
<td>Depressive disorder</td>
<td>70</td>
<td>115</td>
<td>130</td>
<td>127</td>
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<tr>
<td>Liver</td>
<td>33</td>
<td>124</td>
<td>178</td>
<td>72</td>
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<td>Schizophrenia</td>
<td>152</td>
<td>36</td>
<td>69</td>
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<tr>
<td>Kidney</td>
<td>24</td>
<td>79</td>
<td>83</td>
<td>39</td>
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<td>Urolithiasis</td>
<td>10</td>
<td>60</td>
<td>62</td>
<td>35</td>
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<tr>
<td>Housing</td>
<td>60</td>
<td>23</td>
<td>39</td>
<td>40</td>
<td>36</td>
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</table>
Social Determinants of Health

How do we address patient's needs?

- Utilize Social Determinants of Health Screening tool
- Link to community resources
- Follow-Up
SDOH Standard Work

1. Scrub for SDOH
2. Handout SDOH Form
3. Document results in EMR
4. Review results
5. Follow-Up on positive results

Roles:
- Medical Assistant
- Medical PSR
- Provider
- Wellness Coach
Lessons Learned in PDSA work

By using small scale tests we can quickly learn from mistakes and correct.

Lessons Learned:

- By first running our predictive model with 100 patients we were able to convince ourselves that our risk model did an okay job of indicating who is more complex.
- We learned that you cannot isolate only patients that do not have mental health or SUD issues.
- Need to involve all of the team from the start
Plan-Do-Study-Act

<table>
<thead>
<tr>
<th>Team</th>
<th>West Medford</th>
<th>PDSA Cycle</th>
<th>Cycle 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What are we trying to accomplish?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrate Care Coordination efforts for high risk patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will we know change is an improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have a useable workflow in place that can be duplicated at other sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What will we test?</td>
<td>Follow process to create care plans for all 4, 5, &amp; 6 patients at West Medford.</td>
<td>Timeline</td>
<td>6/25/-7/15</td>
</tr>
<tr>
<td>Measure</td>
<td>% of 4,5,&amp;6 patients with a care plan</td>
<td>Hypothesis</td>
<td>80% of patients will have a complete care plan in place</td>
</tr>
</tbody>
</table>
Plan-Do-Study-Act (1st draft workflow)

1. List is received
2. Determine what test group to work with
3. Give List to EPS
4. Add Flag for Risk Level 4, 5, & 6
5. Is there an appointment scheduled?
6. Add appt. note with risk level
7. EPS will schedule appointment and add appt. note with risk level.
8. Day of appt. patient will be brought to team huddle. CMN will facilitate discussion using scrubbing tool and dot phrase
9. Add the Level to the problem list and add a flag
10. Patient evaluation, determine what care level is required
11. Team determines care plan. This must include:
   - self management goals
   - goals of preventive and chronic illness care
   - action plan for exacerbations of chronic illness
12. Care plan in Epic, using dot phrases and putting in letter

Level 4 = Rising Risk
Level 5 = High Risk
Level 6 = Very High Risk

Case Management Nurses
EPS
Team
Site Coordinator
Plan-Do-Study-Act

**Do- What happened? Were their surprises?**

1. Behavioral Health and Wellness coaches were needed from the beginning and they were caught off guard.
2. Felt overwhelming for case management
3. Did not have a good understanding of what would go in a care plan, who the care team was, or how that first conversation with the patient should go.

**Study- What did you learn?**

1. Need to have a better plan for care planning itself, did not set this up so that you would have interaction and input from the patient. This is about the patient, for the patient, with the patient.
2. Timeline was too short.
3. Needed to have a smaller test population, one provider.
4. You cannot separate out behavioral health and addiction, it just doesn’t work that way. Wellness coach and Behavioral health are integral to the process.
5. Need to incorporate readiness for change.

**Act- What are the next steps? Next cycle?**

1. Smaller test population.
2. More work to create a care plan tool and better understanding of what that is and how to use.
3. Complete care team in place
Care Coordination

Focus is now on creating workflows for coordinated care that promote team-based healthcare practices.

- Use of Team Huddles- way to actively manage quality and safety, and a way to ensure care coordination sticks.
- Create workflows that incorporate the whole team
- Keep workflows up to date
- Just get in there and get started, it does not need to be perfect!
Next Steps

- What are we working on now
  - Continue to Use the PDSA testing cycles to further develop care coordination at each site
  - Better integrate the SDOH into the risk modeling
What could the Future Hold……

- Understanding life cycle or risk, what drives patient up this cycle and what actions improve risk, and health outcomes for patients
- Panel adjustments for providers
- Drive ED utilization down
- Understand Patient Population
- Spreading interventions that work to all health care centers at LaClinica
- What interventions are working
- Hiring Practices
- Care team development
Thank you!