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

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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?

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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

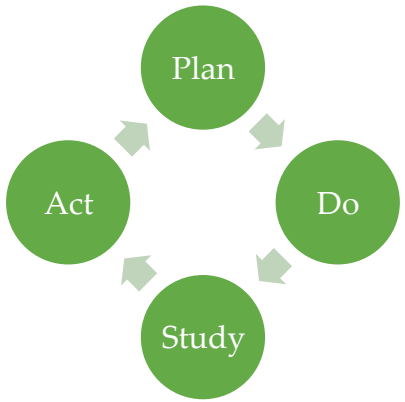
How do we know when we are successful?

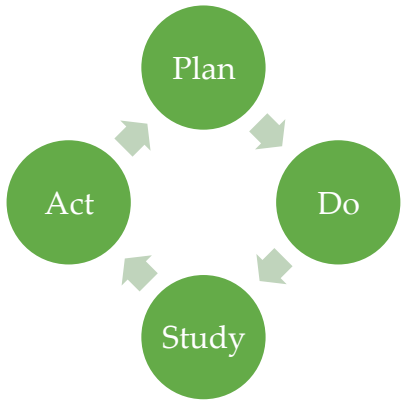
What is the measurement of success? How do we know when this project has been completed?

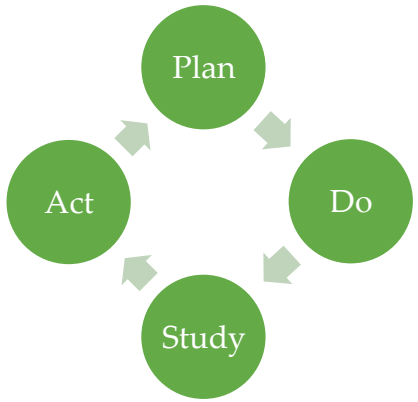
- Risk scores that have been vetted by our clinical staff
- Documented workflows that promote team-based care
- Will be tracking patient risk over time to see impact of work
- Communication/Implementation Plan
- On-going improvement plan

What is our approach

Explore → Engage → Examine → Execute → Ensure Excellence







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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**

Line of Business	Plan	Metro Expansion
Medicaid Primary	Jackson Care Connect	(All)

Select **Region and Clinic Attributes**

RCT	Region Number	Bridge	Clinic
Jackson	Null	Null	(Multiple values)

Total	=	Healthy	+	Low Risk	+	Rising Risk	+	High Risk
6,669 Members (100%)		5,058 Members (76%)		656 Members (10%)		897 Members (13%)		58 Members (1%)
$21M Paid (100%)		$5M Paid (23%)		$2M Paid (10%)		$10M Paid (49%)		$4M Paid (19%)

Cost & Risk

Cohort	Segment	Members	% Total Members	% Total Cost	Avg. Total Cost	Avg. Medical Cost	Avg. Rx Paid	ACG- Avg. Prob High Total Cost	ACG-Avg. Prob High Rx Cost	ACG-Avg. Prob IP Hosp 6 Mth	ACG-Avg. Prob of IP Hosp	Avg. DTCR Risk Score
Healthy	Healthy Kids	1,775	26.62%	3.94%	$468	$425	$43	0.01	0.00	0.00	0.01	0.00
	Healthy Adults	3,283	49.23%	18.62%	$1,196	$1,011	$185	0.03	0.02	0.01	0.02	2.63
Low Risk	Acute Kids & Adults	528	7.92%	4.84%	$1,931	$1,794	$138	0.04	0.01	0.02	0.03	2.74
	Maternity	128	1.92%	4.97%	$8,181	$8,122	$59	0.05	0.01	0.01	0.02	3.09
Rising Risk	Chronic Managed	578	8.67%	23.88%	$8,715	$7,211	$1,503	0.15	0.16	0.06	0.10	6.30
	Uncoordinated	140	2.10%	5.48%	$8,253	$7,511	$742	0.11	0.08	0.07	0.11	6.15
	Chronic Uncoordinated	162	2.43%	15.79%	$20,554	$17,099	$3,455	0.27	0.24	0.13	0.19	6.96
	Complex Managed	17	0.25%	3.75%	$46,554	$41,684	$4,870	0.49	0.42	0.19	0.27	9.06
High Risk	High Rx	23	0.34%	8.37%	$76,790	$7,552	$69,238	0.38	0.92	0.09	0.14	6.09
	SA/SMI/ Chronic	8	0.12%	1.01%	$26,555	$21,327	$5,228	0.32	0.21	0.22	0.33	12.65
	Extremely Complex	27	0.40%	9.35%	$73,047	$61,977	$11,070	0.56	0.42	0.39	0.49	11.91
Grand Total		6,669	100.00%	100.00%	$3,162	$2,515	$647	0.05	0.04	0.02	0.03	2.52

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

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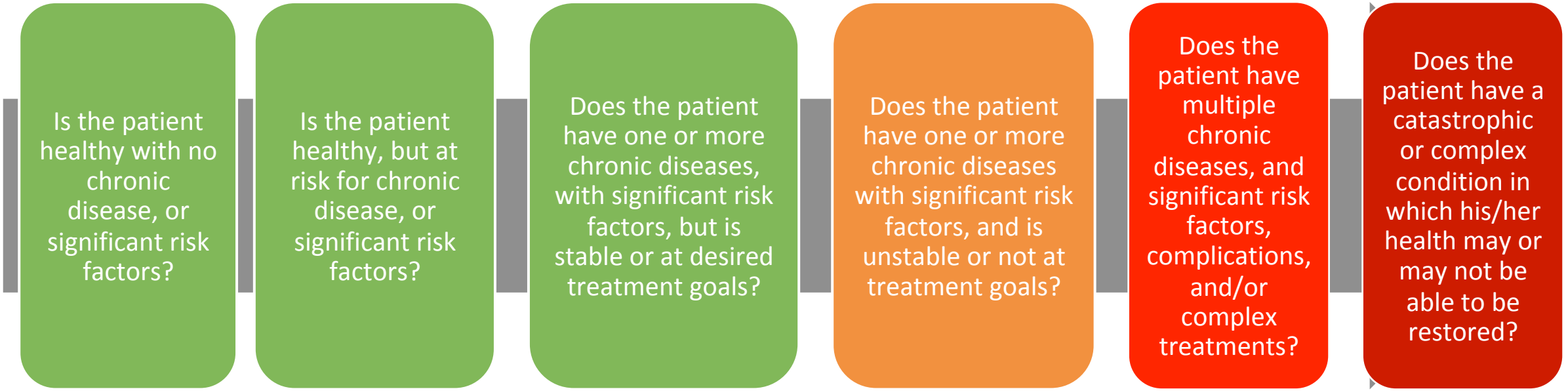
Risk Stratification

Cohorts



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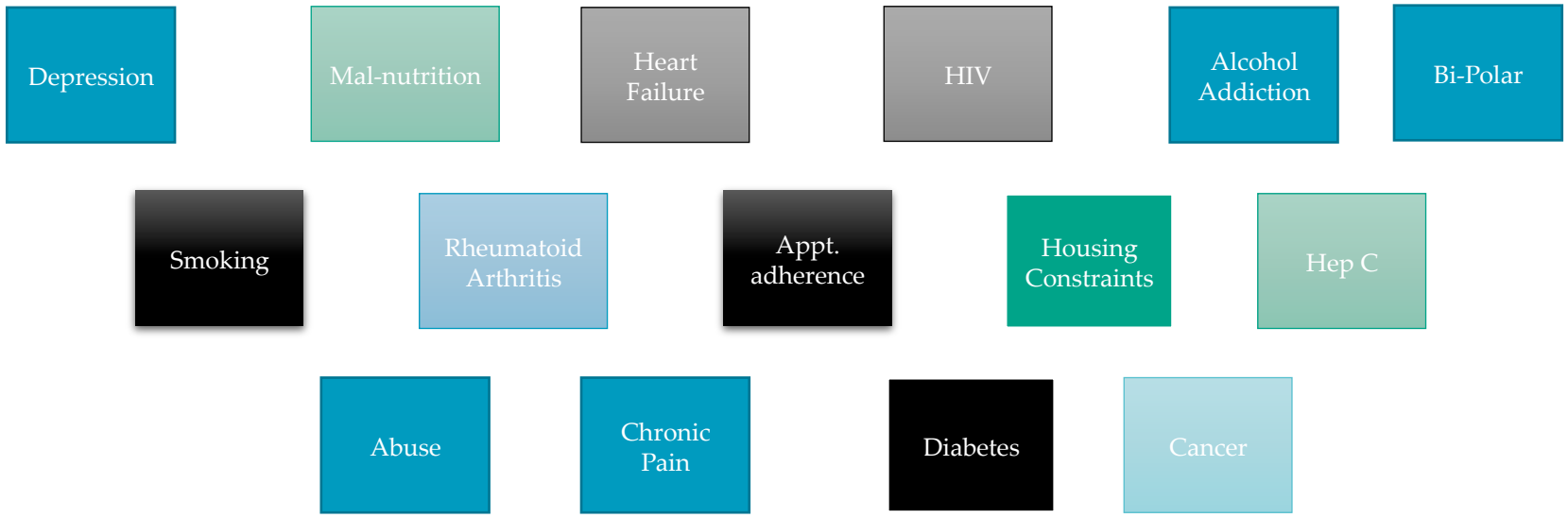
Risk Stratification Calculation

Medical Conditions	Mental Health
Substance Abuse Disorders	Social Determinates of Health
Pain	Clinic Utilization
Appointment Adherence	Personal Behaviors



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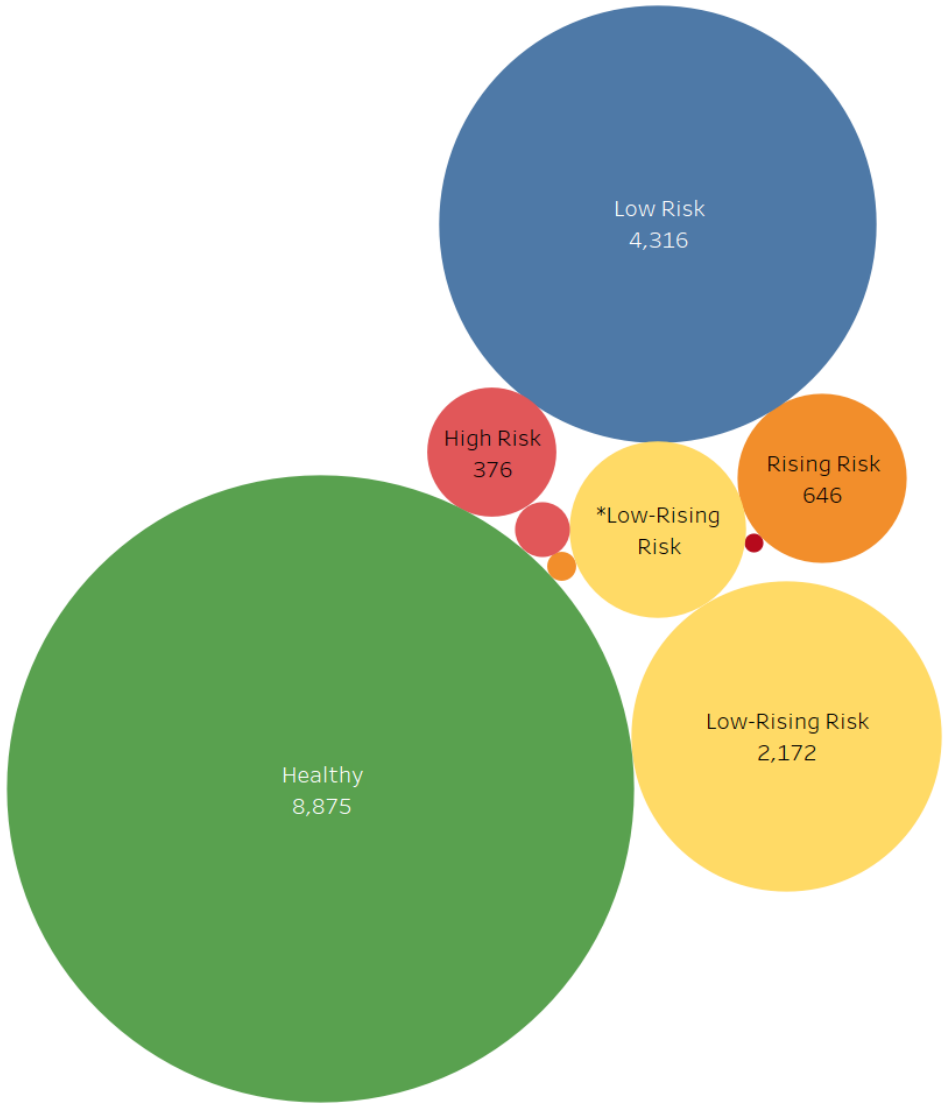
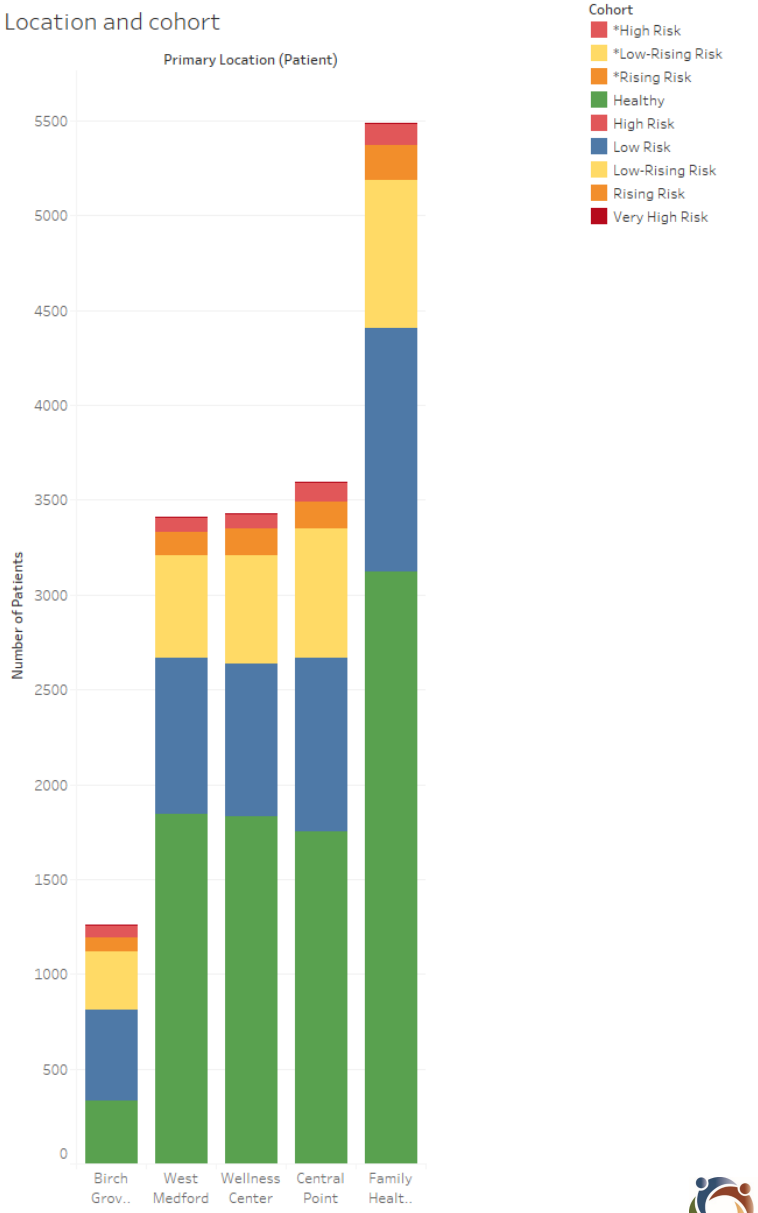
Cohort Breakdown- All HC



Location and cohort



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Prevalent Risk Indicators

Risk by Catagory

	Primary Location (Patient)					
Detail	Birch Grove Health Center	Central Point	Family Health Care Center	Wellness Center	West Medford	Grand Total
Non-Adherence	523	779	987	862	864	4,015
Obesity	192	777	1,062	932	657	3,620
Hypertension	197	902	1,070	639	589	3,397
Anxiety	366	630	768	598	518	2,880
Nicotine	337	592	660	442	574	2,605
Respiratory disease	195	520	597	415	387	2,114
SUD	455	350	520	265	318	1,908
Diabetes	89	393	547	318	336	1,683
Chronic Pain	148	337	301	359	286	1,431
Circulatory system	66	309	345	193	189	1,102
Other mental health disor..	130	217	257	187	180	971
PTSD	147	164	182	171	116	780
Bipolar	173	122	187	138	123	743
Complex Care	45	165	188	97	158	653
SDOH	86	105	145	150	101	587
Cancer	24	167	174	92	105	562
Depressive disorder	70	115	130	127	117	559
Liver	35	124	178	72	82	491
Schizophrenia	152	36	69	38	46	341
Kidney	24	79	83	39	55	280
Urolithiasis	10	60	62	35	34	201
Housing	60	23	39	40	36	198

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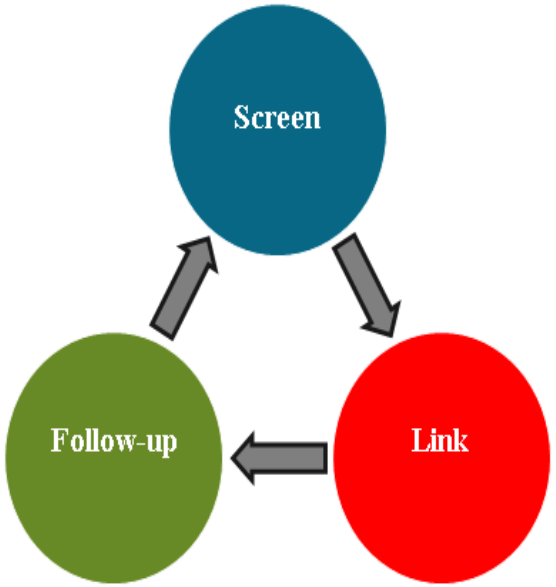
Social Determinants of Heatlh

How do we address patient's needs?

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



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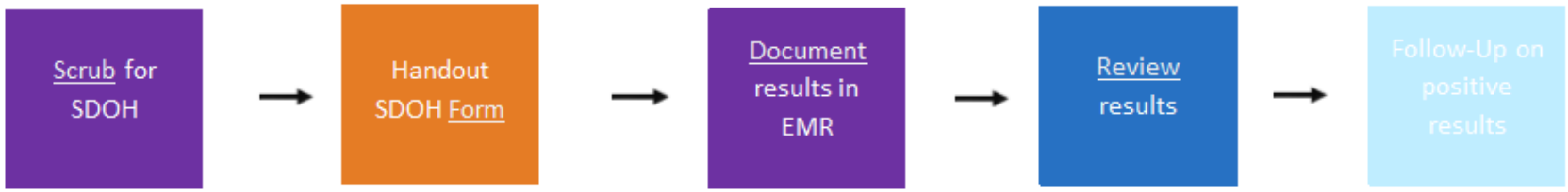
SDOH Standard Work



- Medical Assistant
- Medical PSR
- Provider
- Wellness Coach

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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 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

Team	West Medford	PDSA Cycle	Cycle 2
What are we trying to accomplish?			
Integrate Care Coordination efforts for high risk patients			
How will we know change is an improvement			
Have a useable workflow in place that can be duplicated at other sites			
Plan			
What will we test?	Follow process to create care plans for all 4,5, & 6 patients at West Medford.	Timeline	6/25/-7/15
Measure	% of 4,5,&6 patients with a care plan	Hypothesis	80% of patients will have a complete care plan in place

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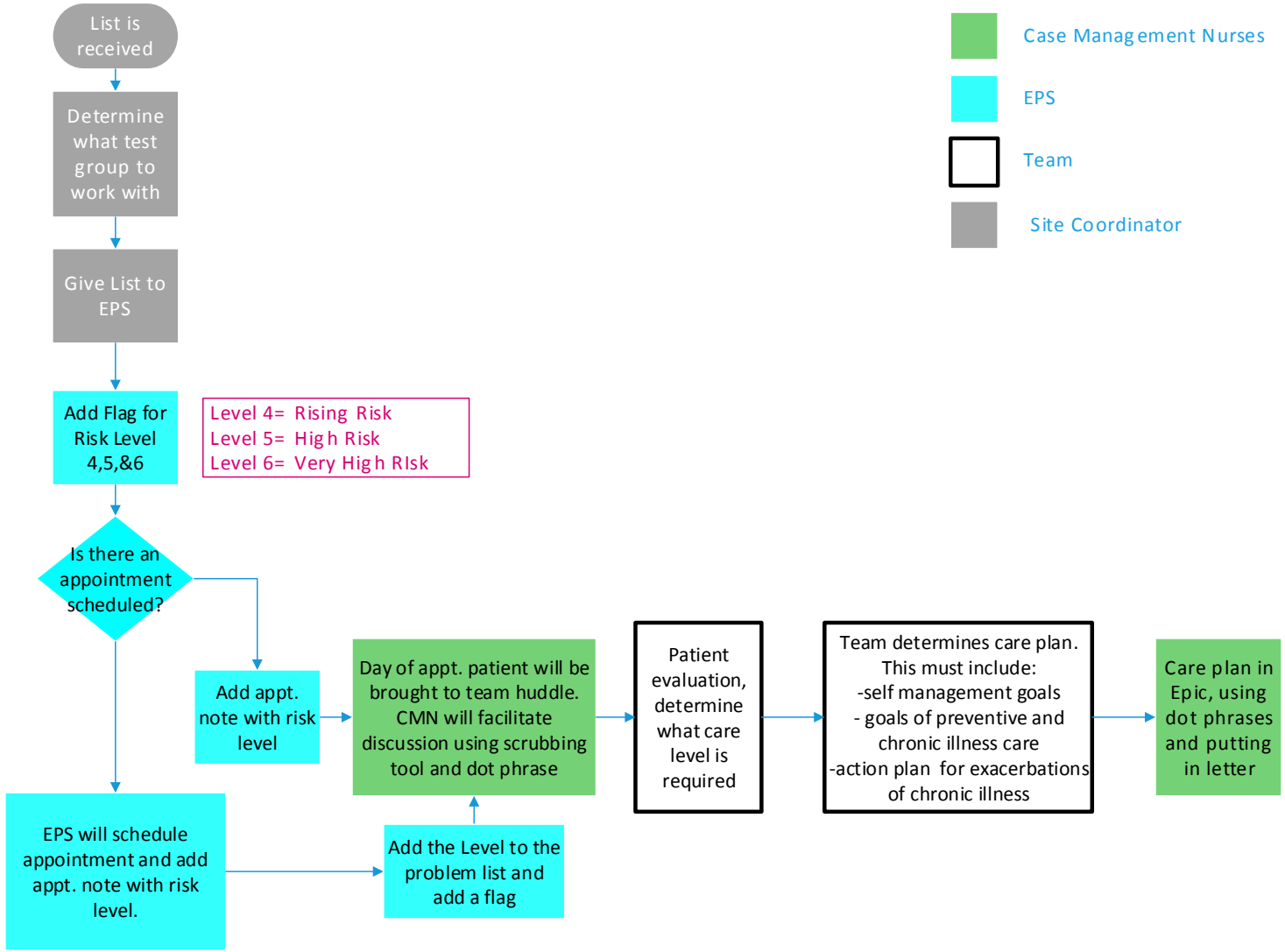
Plan-Do-Study-Act (1st draft workflow)



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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

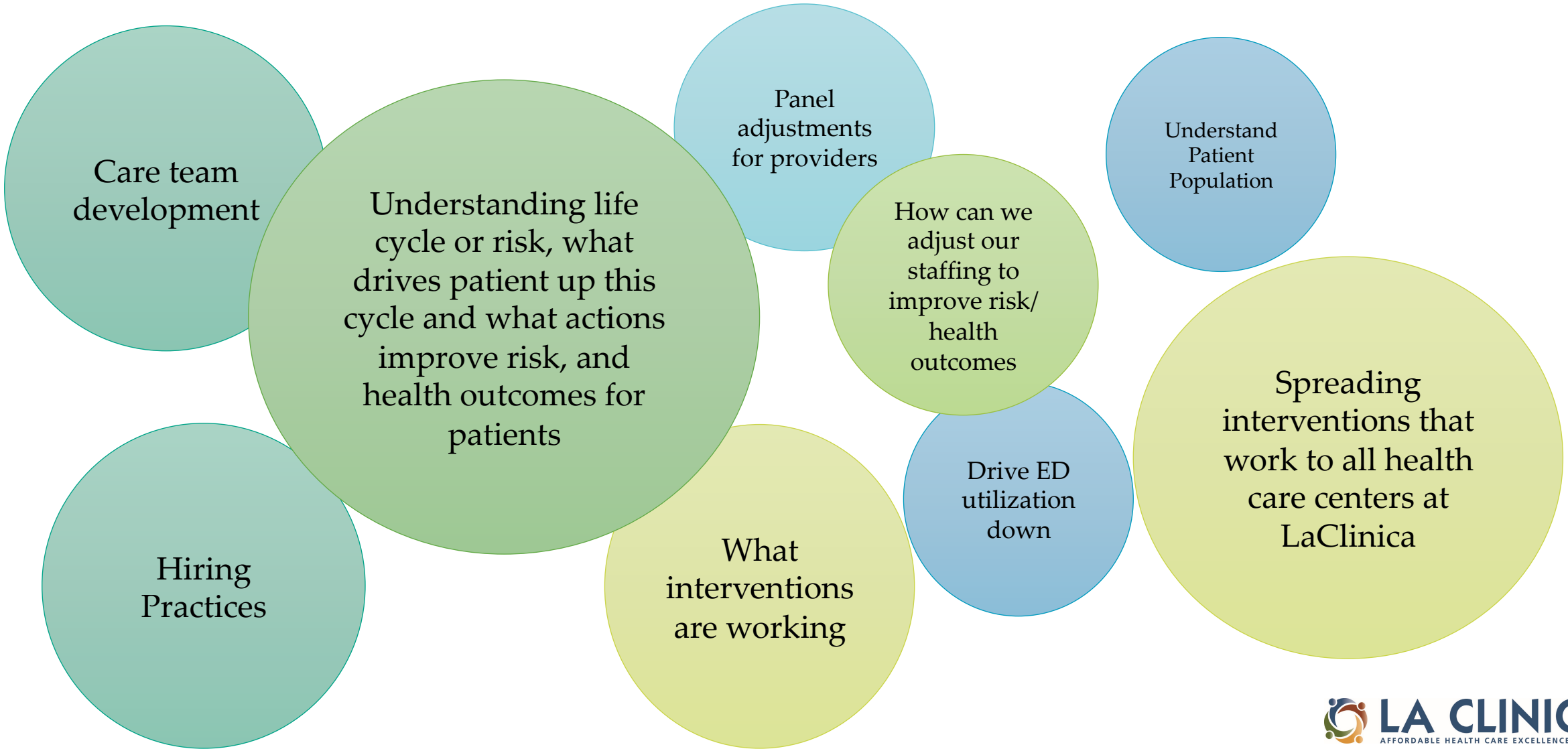
Focus is now on creating workflows for coordinated care that promote team-based healthcare practices.

- 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……



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Thank you!

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