NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Risk Stratification

Peer Exchange Session, Part 2 of 3

03.12.2020

THE NACHC MISSION

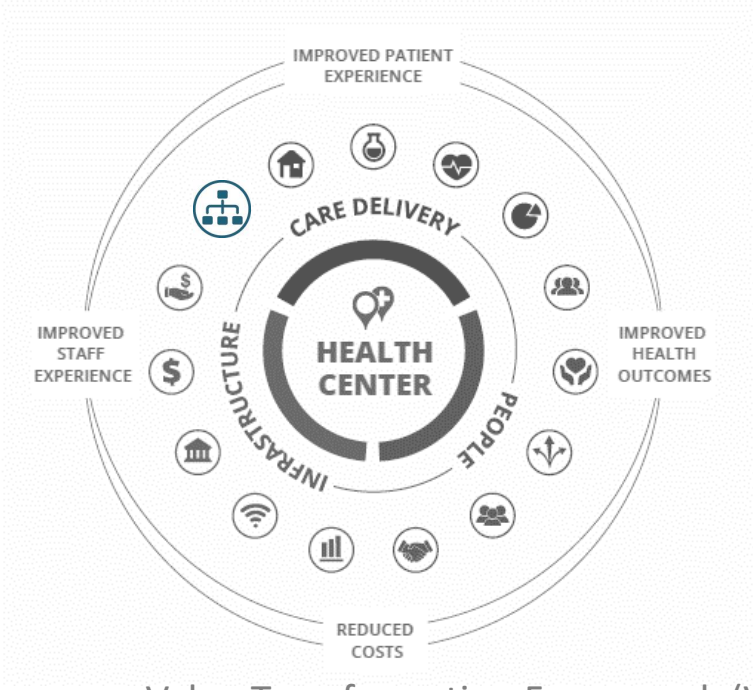
America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF Community Health Centers®

Agenda:

- **Risk Stratification & EHR/HIT**
- **Risk Stratification**
- **Risk Stratification: COVID-19**
- **Models of Care**



Value Transformation Framework (VTF)

Population Health Management

HIT & Risk Stratification

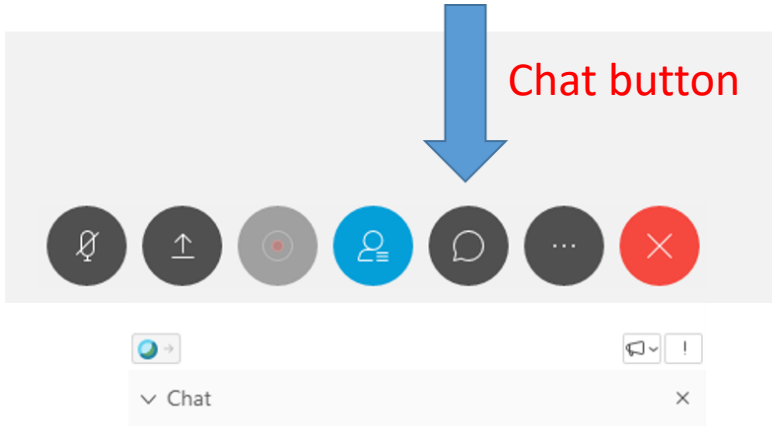
Foundational Importance of Health Information Technology (HIT)

- Required for risk stratification efforts
- Utilize to run registries and other patient lists
- Combine EHR capabilities with population health tools

Use “chat” to let us know:

What topic/area of focus would you like to see in an evidence-based HIT Action Guide?

How to Participate



- Click the chat button at the bottom of the WebEx window which will open the chat box on the bottom righthand side of the window.
- Choose “All Participants”. Type your question/comment. Click “Enter” to send it.
- If you would like to speak, select the small hand icon next to your name.

Action Guide

NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

POPULATION HEALTH MANAGEMENT

RISK STRATIFICATION

WHY

Risk Stratification?

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.

Population health management requires practices to consider patients as both individuals and as members of a larger community or population. At the individual level, a patient's risk category is the first step towards planning, developing, and implementing a personalized care plan. One common method of segmenting patients is by "risk" level: high-, medium- (rising), and low- risk. At the population level, risk stratification allows care models to be personalized to the needs of patients within each subgroup. (See Models of Care Action Guide.)

POPULATION HEALTH MANAGEMENT

The Value Transformation Framework addresses how health centers can use a systematic process for utilizing data on patient populations to target interventions for better outcomes, with a better care experience, at a lower cost. This Action Guide focuses on one foundational component of population health management: risk stratification.

A "one-size-fits-all" model, where the same level of resources is offered to every patient, is clinically ineffective and prohibitively expensive. To maximize efficiency and improve outcomes, health centers must analyze their patient population and customize care and interventions based on identified risks and costs[1,2,3,4,5]. Healthy patients, for instance, may not want a high level of intensive support, and can be engaged through alternate models of care[2]. With this in mind, high-intensity resources can and should be reserved for high-risk patients. Care models based on risk with customized care at each level can flexibly match need with more appropriate resources[1,2,3,4,5]. Top-performing, population health-focused organizations practice risk stratification.

WHAT

is Risk-Stratification?

The goal of risk stratification is to segment patients into distinct groups of similar complexity and care needs. For example, out of every 1,000 patients in a panel, there will likely be close to 200 patients (20%) who could benefit from more intensive support. This 20% of the population accounts for 80% of the total health care spending in the United States[5,6]. Of these "higher need" patients, five percent (5%) account for nearly half of U.S. health expenditures[6,7]. Health care spending for people with five or more chronic conditions is 17 times higher than for people with no chronic conditions[8].

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[Risk Stratification Action Guide]

Population Health Management

Step 1: Compile a List of Health Center Patients

Step 2: Sort Patients by Condition

Step 3: Stratify Patients to Segment the Population into Target Groups

Step 4: Design Care Models and Target Interventions for Each Risk Group

Peer Exchange

February 27th Key Messages

- “We use Azara to identify the risk level of each patient, and have sorted patients by condition and then risk level within the condition. We are using this method to ID patients in need of care management and also those who are at risk for hospital admission.”

  -- Sue Vrobel, Grace Health

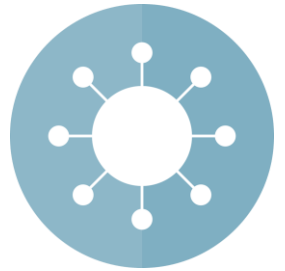
- We haven't defined our models of care yet, but we think that it might be able to help us budget appropriately for the right number of staff (physicians, dieticians, care coordinators, health educators) at each site depending on the number of each risk level of patients.

  -- Christine Park, Northeast Valley Health Corporation

Discussion:

Since last call, any actions/advancement in your health center's work around risk stratification?

Systems Approach…Cancer Screening, Diabetes, HTN, COVID-19…or Other



1 **Leadership Support**

2 **Risk Stratification**

- Community
- Patient
- Staff

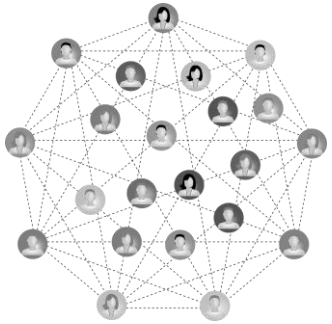
3 **Models of Care**

4 **Optimized Care Teams**

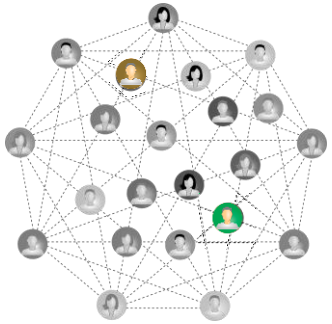
Community Segmentation

https://www.who.int/publications-detail/critical-preparedness-readiness-and-response-actions-for-covid-19

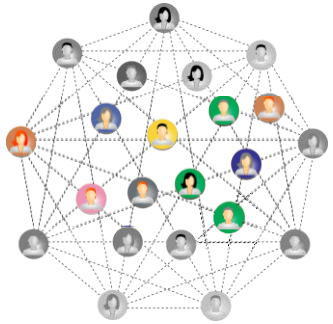
World Health Organization (WHO) Recommendations:



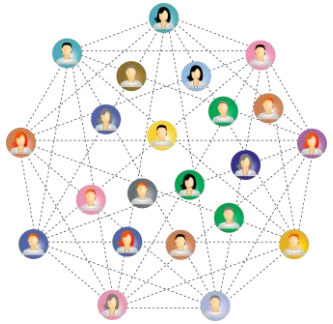
0 cases



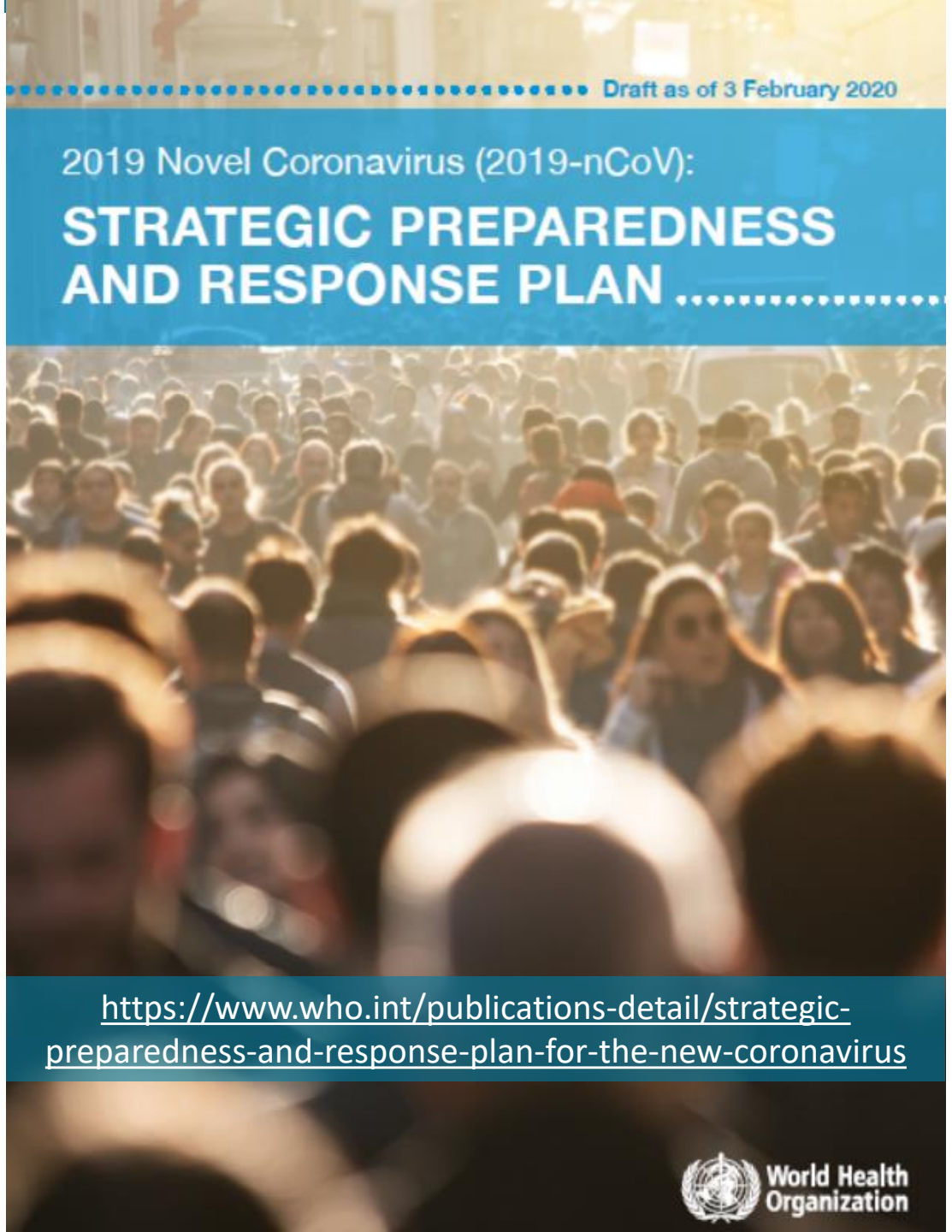
1 or more cases



Case clusters (in time, geographic location, and/or common exposure)



Larger outbreaks of local transmission (community transmission)



https://www.who.int/publications-detail/strategic-preparedness-and-response-plan-for-the-new-coronavirus

World Health Organization

COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PLAN
Country Preparedness and Response Status for COVID-19
as of 11 March 2020

All countries are at risk and need to prepare for and respond to COVID-19. Each country is encouraged to plan its preparedness and response actions in line with the global Strategic Preparedness and Response Plan[1].

https://www.who.int/internal-publications-detail/updated-country-preparedness-and-response-status-for-covid-19-as-of-11-march-2020

Visit WHO's website to view this resource: https://www.who.int/publications-detail/critical-preparedness-readiness-and-response-actions-for-covid-19

Table 1. Critical preparedness, readiness and response actions for each transmission scenario for COVID-19

	No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
Transmission scenario	No reported cases	One or more cases, imported or locally acquired.	Most cases of local transmission linked to chains of transmission.	Outbreaks with the inability to relate confirmed cases through chains of transmission for a large number of cases, or by increasing positive tests through sentinel samples (routine systematic testing of respiratory samples from established laboratories.
Aim	Stop transmission and prevent spread.	Stop transmission and prevent spread	Stop transmission and prevent spread.	Slow transmission, reduce case numbers, end community outbreaks.
Priority areas of work				
Emergency response mechanisms.	Activate emergency response mechanisms.	Enhance emergency response mechanisms.	Scale up emergency response mechanism.	Scale up emergency response mechanism
Risk communication and public engagement.	Educate and actively communicate with the public through risk communication and community engagement.	Educate and actively communicate with the public through risk communication and community engagement.	Educate and actively communicate with the public through risk communication and community engagement.	Educate and actively communicate with the public through risk communication and community engagement.
Case finding, contact tracing and management.	Conduct active case finding, contact tracing and monitoring; quarantine of contacts and isolation of cases.	Enhance active case finding, contact tracing and monitoring; quarantine of contacts and isolation of cases.	Intensify case finding, contact tracing, monitoring, quarantine of contacts, and isolation of cases.	Continue contact tracing where possible, especially in newly infected areas, quarantine of contacts, & isolation of cases; apply self-initiated isolation for symptomatic individuals.
Surveillance	Consider testing for COVID-19 using existing respiratory disease surveillance systems and hospital-based surveillance.	Implement COVID-19 surveillance using existing respiratory disease surveillance systems and hospital-based surveillance.	Expand COVID-19 surveillance using existing respiratory disease surveillance systems and hospital-based surveillance.	Adapt existing surveillance systems to monitor disease activity (e.g. through sentinel sites).
Public health measures.	Hand hygiene, respiratory etiquette, practice social distancing.	Hand hygiene, respiratory etiquette, practice social distancing.	Hand hygiene, respiratory etiquette, practice social distancing.	Hand hygiene, respiratory etiquette, practice social distancing.

CDC's Framework for Mitigation

Factor	Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting		
	None (preparedness phase)	Minimal to moderate	Substantial
Healthcare settings and healthcare provider (includes outpatient, nursing homes/long-term care facilities, inpatient, telehealth) "What healthcare settings including nursing homes/ long-term care facilities, can do to prepare for COVID-19, if the facilities has cases of COVID-19, or if the community is experiencing spread of COVID-19)"	• Provide healthcare personnel ([HCP], including staff at nursing homes and long-term care facilities) and systems with tools and guidance needed to support their decisions to care for patients at home (or in nursing homes/long-term care facilities). • Develop systems for phone triage and telemedicine to reduce unnecessary healthcare visits. • Assess facility infection control programs; assess personal protective equipment (PPE) supplies and optimize PPE use. • Assess plans for monitoring of HCP and plans for increasing numbers of HCP if needed. • Assess visitor policies. • Assess HCP sick leave policies (healthcare facilities should provide non-punitive sick leave options to allow HCP to stay home when ill). • Encourage HCP to stay home and notify healthcare facility administrators when sick. • In conjunction with local health department, identify exposed HCP, and implement recommended monitoring and work restrictions. • Implement triage prior to entering facilities to rapidly identify and isolate patients with respiratory illness (e.g., phone triage before patient arrival, triage upon arrival).	• Implement changes to visitor policies to further limit exposures to HCP, residents, and patients. Changes could include temperature/ symptom checks for visitors, limiting visitor movement in the facility, etc. • Implement triage before entering facilities (e.g., parking lot triage, front door), phone triage, and telemedicine to limit unnecessary healthcare visits. • Actively monitor absenteeism and respiratory illness among HCP and patients. • Actively monitor PPE supplies. • Establish processes to evaluate and test large numbers of patients and HCP with respiratory symptoms (e.g., designated clinic, surge tent). • Consider allowing asymptomatic exposed HCP to work while wearing a facemask. • Begin to cross train HCP for working in other units in anticipation of staffing shortages.	• Restrict or limit visitors (e.g., maximum of 1 per day) to reduce facility-based transmission. • Identify areas of operations that may be subject to alternative standards of care and implement necessary changes (e.g., allowing mildly symptomatic HCP to work while wearing a facemask). • Cancel elective and non-urgent procedures • Establish cohort units or facilities for large numbers of patients. • Consider requiring all HCP to wear a facemask when in the facility depending on supply.

Mitigation: *actions that persons and communities can take to help slow the spread of disease.*

CDC's list of potential mitigation activities according to level of community transmission or impact of COVID-19, by setting

Patient Segmentation

Risk Level	Examples	Monitoring Approach	Strategy	Plan if fever or respiratory symptoms* develop
Low	Brief interactions or prolonged close contact with infected patients wearing a mask while staff also wearing mask/respirator. Certain procedures (e.g., generating respiratory secretions) elevate risk level.	Self+	Take temperature 2x/day. Monitor for respiratory symptoms	Provide a plan regarding who to notify if fever or respiratory symptoms develop
Medium	Prolonged close contact with infected patients wearing mask while staff nose/mouth exposed	Active+	Communication/check-in by state/local public health authority or delegate for presence of fever or respiratory symptoms at least daily	Self-isolate. Plan for medical evaluation. Exclude from work for 14 days after last exposure.
High	Prolonged close contact with patients not wearing a mask while staff nose/mouth exposed. Present in room for procedures that generate respiratory secretions.	Active+	Communication/check-in by state/local public health authority or delegate for presence of fever or respiratory symptoms at least daily	Self-isolate. Plan for medical evaluation. Exclude from work for 14 days after last exposure.

The above is a summary of key CDC risk-assessment recommendations. Providers should refer to CDC's website for full and additional details: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#table1

*respiratory symptoms include cough, shortness of breath, sore throat

+Self-monitoring with delegated supervision – health care provider self-monitors with oversight by their health care organization in coordination with the health department.

"Close contact" for healthcare exposures: (a) being within 6 ft of a person with COVID-19 for a prolonged period of time; or (b) unprotected direct contact with infectious secretions/excretions.

Patient Segmentation

Sort by Condition (VTF Action Guide, Step 2)

- **Before Arrival**
  - Ask if patient having respiratory symptoms (cough, runny nose, fever).
  - Ask if patient has travelled to any CDC identified high risk travel areas
  - Ask if patient has been exposed to someone who may be infected with the virus (past 14 days).

If yes to any of the above, use nurse-directed triage protocols to determine if an appointment is needed for patient can be managed at home.

If an patient will be seen, instruct on procedure for arrival (separate registration or entrance? Wear mask, scar or handkerchief to shield coughing until arrival; mask/tissue provided upon arrival); referral to emergency care, if needed.

Patient Segmentation

- **Upon Arrival/During Visit**
  - At points of entry and in facility, provide 60-90% alcohol-based hand sanitizer, tissues, no touch receptacles for disposal and face masks. Post signs/instruction to keep sneeze/coughs covered, hand hygiene, proper disposal of tissues.
  - Implement triage procedures at check-in/registration for all patients: ask about respiratory symptoms and travel to areas experiencing transmission or contact with possible COVID-19 patients. Install physical barrier (e.g., plastic/glass windows) at reception areas to limit close contact between triage/reception and potentially infected patients.
  - Rapid triage and isolation of patients with respiratory symptoms. Consider triage outside the facility – before patients enter.
  - Create separate waiting area for patients with respiratory infection at least 6 feet from rest of the patient population. If appropriate and medically stable, consider option for patients to wait in personal vehicle our outside the facility to be contacted via mobile phone when it is their turn.
  - Notify health center and public health authorities of possible COVID-19 infection.

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html

Healthcare Professional Preparedness Checklist

https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp-preparedness-checklist.pdf

Stay up to date on the latest information about signs and symptoms, diagnostic testing, and case definitions for coronavirus disease 2019.

Review your infection prevention and control policies and CDC infection control recommendations for COVID-19 for:

- Assessment and triage of patients with acute respiratory symptoms ☐
- Patient placement ☐
- Implementation of Standard, Contact, and Airborne Precautions, including the use of eye protection ☐
- Visitor management and exclusion ☐
- Source control measures for patients (e.g., put facemask on suspect patients) ☐
- Requirements for performing aerosol generating procedures ☐
- Be alert for patients who meet the persons under investigation (PUI) definition ☐
- Know how to report a potential COVID-19 case or exposure to facility infection control leads and public health officials. ☐
- Know who, when, and how to seek evaluation by occupational health following an unprotected exposure (i.e., not wearing recommended PPE) to a suspected or confirmed coronavirus disease 2019 patient. ☐
- Remain at home, and notify occupational health services, if you are ill. ☐
- Know how to contact and receive information from your state or local public health agency. ☐

Testing

CDC

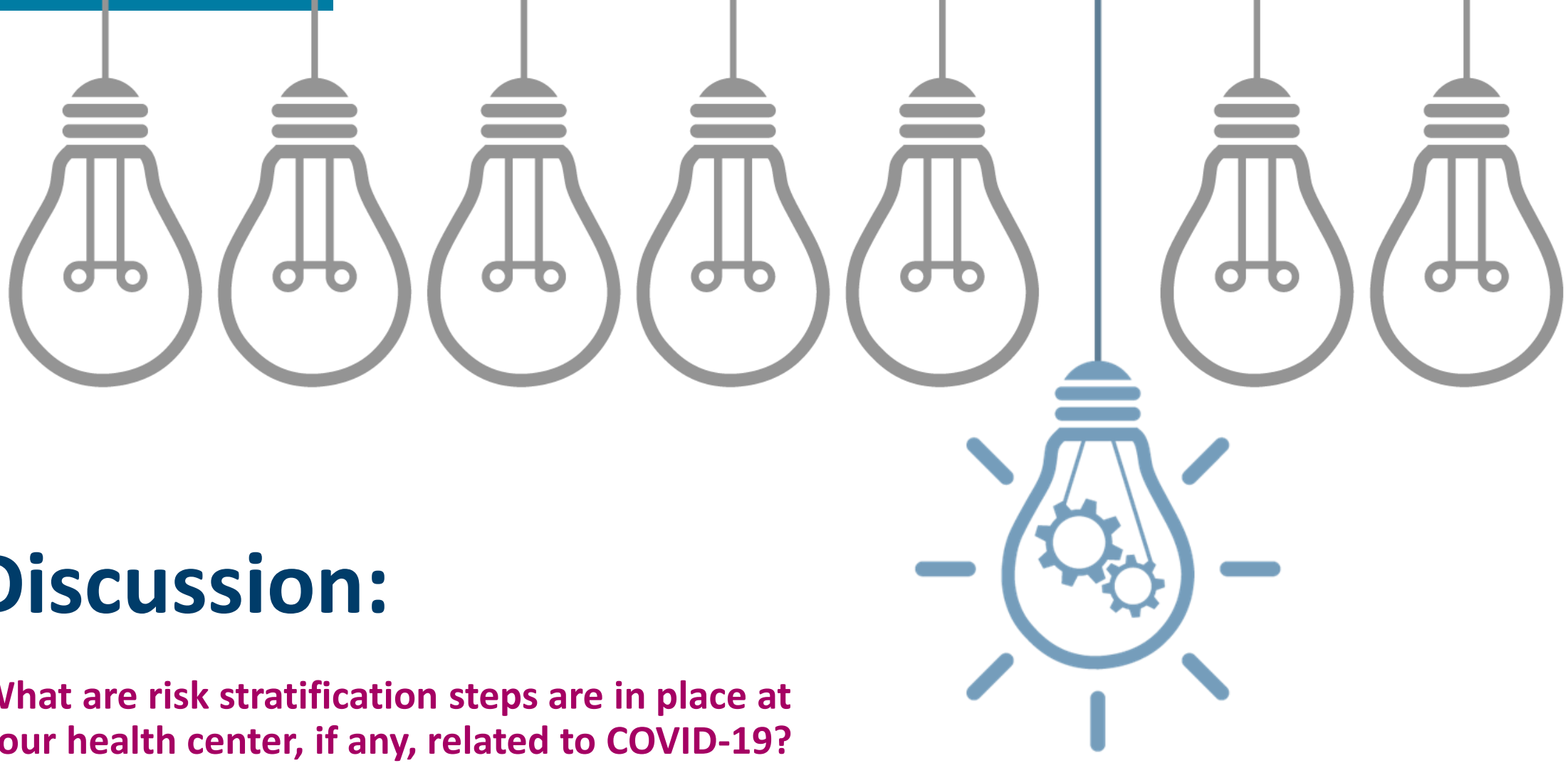
The FDA authorized the CDC to distribute it's diagnostic test to requesting laboratories.

Health Departments

For a map of public health laboratories testing for COVID-19. Contact your state health department for information on testing in your state.

Test Handling

See CDC's website for details on collecting and handling specimens



Discussion:

What are risk stratification steps are in place at your health center, if any, related to COVID-19?

Models of Care

Highly complex. Require intensive, pro-active care management.

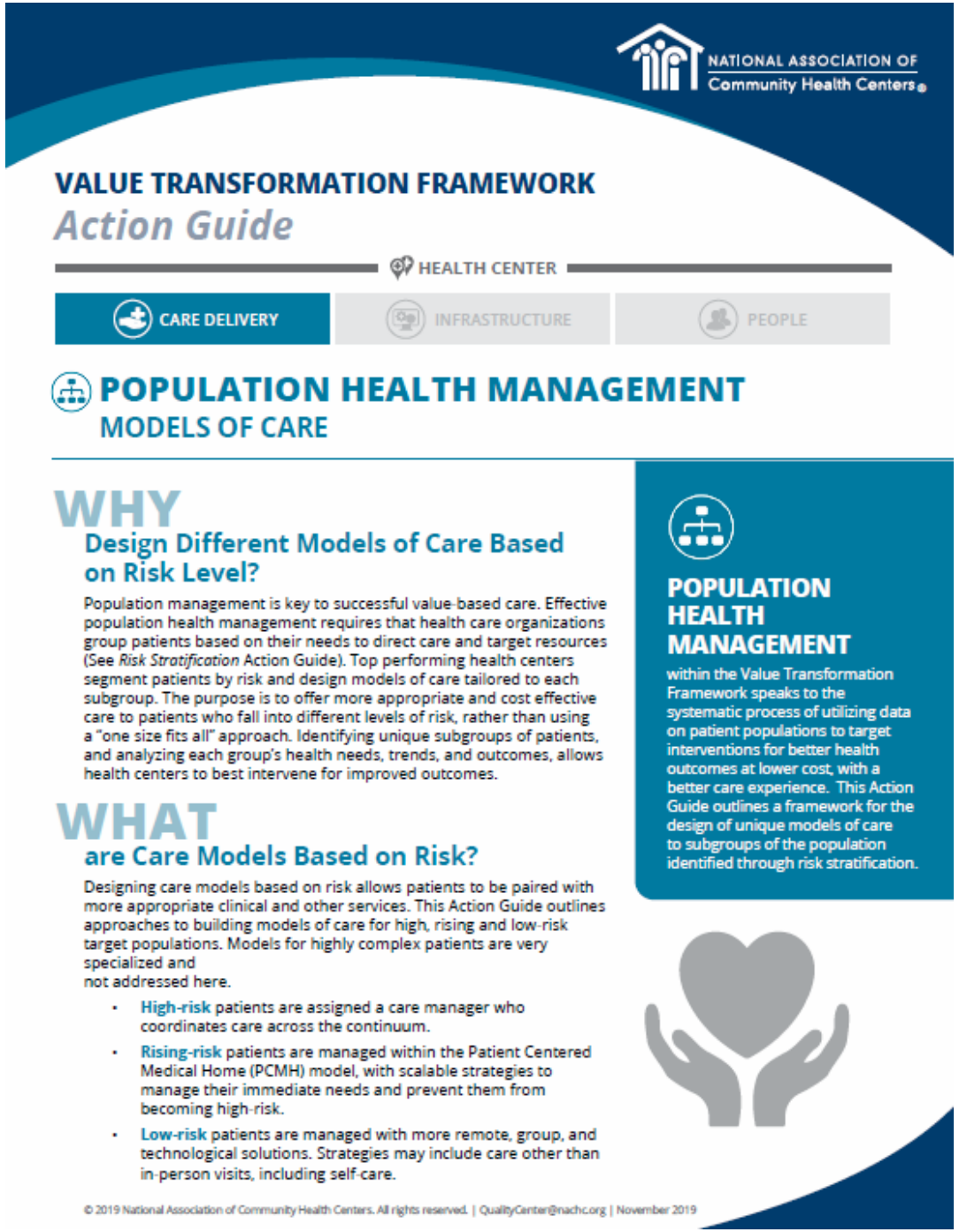
High-risk. Engage in care management to provide one-on-one support for medical, social and care coordination needs.

Rising-risk. Manage within PCMH model; support in managing risk factors (e.g., obesity, smoking, blood pressure, cholesterol).

Low-risk. Manage using more remote, group, and technological solutions; focus on keeping patients healthy and engaged.

Models of Care

http://www.nachc.org/models-of-care-action-guide/



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VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

POPULATION HEALTH MANAGEMENT

MODELS OF CARE

WHY

Design Different Models of Care Based on Risk Level?

Population management is key to successful value-based care. Effective population health management requires that health care organizations group patients based on their needs to direct care and target resources (See *Risk Stratification* Action Guide). Top performing health centers segment patients by risk and design models of care tailored to each subgroup. The purpose is to offer more appropriate and cost effective care to patients who fall into different levels of risk, rather than using a "one size fits all" approach. Identifying unique subgroups of patients, and analyzing each group's health needs, trends, and outcomes, allows health centers to best intervene for improved outcomes.

POPULATION HEALTH MANAGEMENT

within the Value Transformation Framework speaks to the systematic process of utilizing data on patient populations to target interventions for better health outcomes at lower cost, with a better care experience. This Action Guide outlines a framework for the design of unique models of care to subgroups of the population identified through risk stratification.

WHAT

are Care Models Based on Risk?

Designing care models based on risk allows patients to be paired with more appropriate clinical and other services. This Action Guide outlines approaches to building models of care for high, rising and low-risk target populations. Models for highly complex patients are very specialized and not addressed here.

- **High-risk** patients are assigned a care manager who coordinates care across the continuum.
- **Rising-risk** patients are managed within the Patient Centered Medical Home (PCMH) model, with scalable strategies to manage their immediate needs and prevent them from becoming high-risk.
- **Low-risk** patients are managed with more remote, group, and technological solutions. Strategies may include care other than in-person visits, including self-care.

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Models of Care: COVID-19

- CDC - Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Under Investigation for COVID-19 in Healthcare Settings
- CDC - Evaluating and Reporting Persons Under Investigation for COVID-19 infection
- CDC - Interim Clinical Guidance for Management of Patients with Confirmed COVID-19
- CDC - Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons Under Investigation for COVID-19
- CDC - List of Acceptable Commercial Primers & Probes
- CDC Tests for COVID-19
- COVID-19 Persons Under Investigation and Case Report Form

Models of Care: COVID-19 Patient Flow

Care Models by Risk Group (VTF Action Guide, Step 4)

- Where possible, designate separate areas of the facility for PUIs*.
- Isolate PUIs in single patient rooms with the door closed.
- Determine if patient needs to be transferred to a hospital or can be released to home (after proper consultation with public authorities and consideration of medical condition and the suitability of the residential setting for home care.

*Patients under investigation for COVID-19

Models of Care: COVID-19 Staffing

Care Models by Risk Group (VTF Action Guide, Step 4)

- Designate dedicated personnel to the care of persons suspected/know to be infected with COVID-19.
- All staff providing care to PUIs should use personal protective equipment (PPE), including respiratory protection.
- Keep a log of all personnel who care for/enter care rooms of PUIs.
- Maintain staff use of PPE after patient vacates until room has had time for sufficient air clearance of airborne contaminants.
- Use appropriate hand sanitizer before/after patient contact, contact with potentially infectious material, putting on/off PPE, including gloves. Hand washing with soap and water for at least 20 seconds is recommended.

*PUI = Patients under investigation for COVID-19

Models of Care: COVID-19 Equipment & PPE*

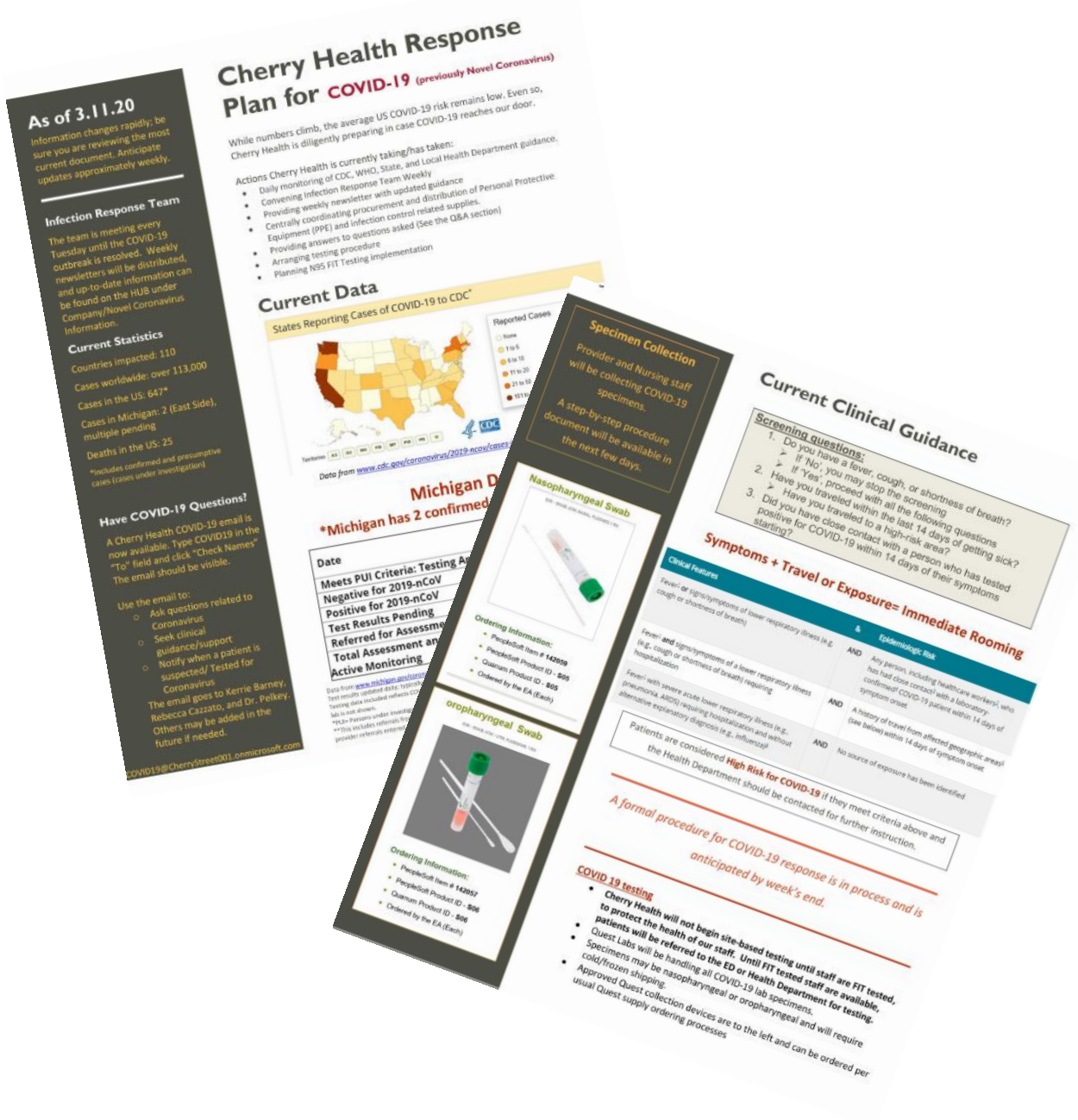
- Use dedicated or disposal equipment (e.g., blood pressure cuffs). If using dedicated equipment, properly disinfect between patients.
- Appropriately disinfect patient care rooms between patient use.
- Provide staff with appropriate PPE (gloves, gowns, respiratory protection & eye protection) and instruction on putting on/removing PPE to prevent contamination (see also the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard.
- Consider engineering controls: partitions to guide patients through triage areas, curtains between patients in shared areas, and appropriate air-handling systems.

*PPE = Personal protective equipment

Sign Up Tomorrow…

Elevate's Learning Platform

It will include great health center resources like this!



Tools & resources to share with peers?

Email:

qualitycenter@nachc.org

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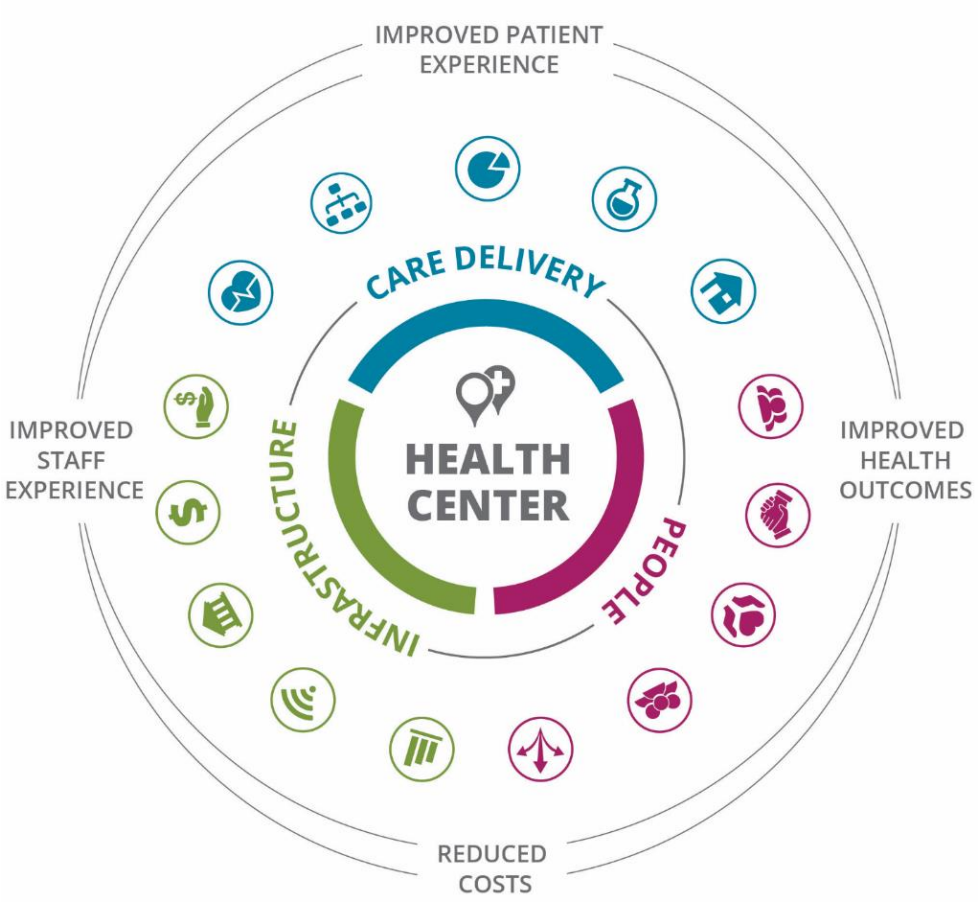
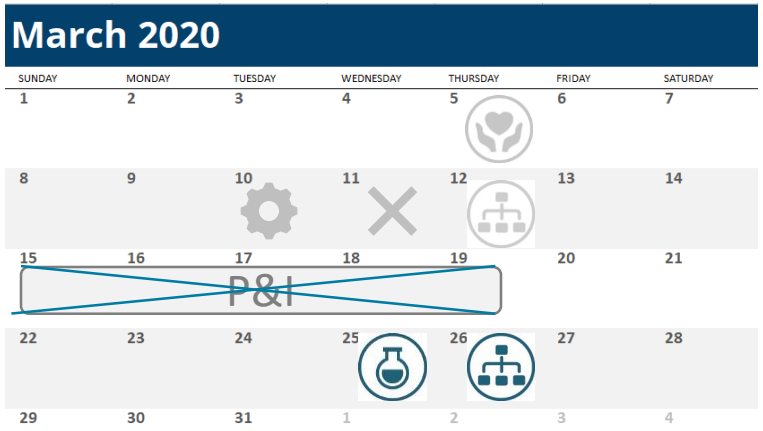
Action Step:

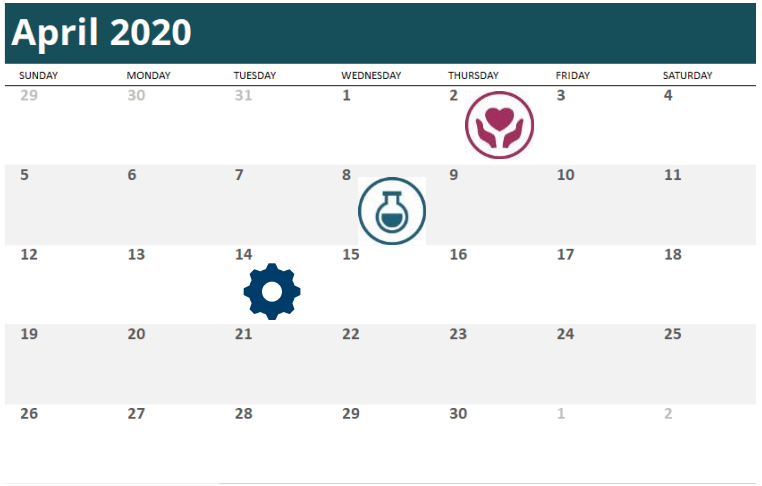
Consider how risk stratification strategies, and the Value Transformation Framework's systems approach to transformation, can support your COVID-19 response



Value Transformation Framework

Calendar





March Forum
03/10 at 1:00 PM EST

Risk Stratification
(eCW; NextGen; GE Centricity/Epic/Athena)
03/12
03/26

Evidence-Based Care
(Cancer; Diabetes, Hypertension)
03/25

April Forum
04/14 at 1:00 PM EST

Leadership
04/02 (30 mins)

Evidence-Based Care
(Cancer; Diabetes, Hypertension)
04/08

May Forum
05/12 at 1:00 PM EST

Leadership
05/07 (30 mins)

Want to add more people to Elevate?

Use the links below to add people to the monthly Elevate invitations and communication

PCAs/HCCNS

http://bit.ly/PCAHCCNind

Health Centers

http://bit.ly/CHCInd

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FEEDBACK

Don't forget! Let us know what you thought about today's session.

FOR MORE INFORMATION CONTACT:

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Next Monthly Forum Call:

April 14th, 2020
1 -2 pm ET

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elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Luke Ertle & Camila Silva