Microlearning: Risk Stratification

Modules	Action Steps	Resources
What?	**STEP 1** ***COMPILE:*** a list of health center patients (building on Empanelment)	NACHC Risk Stratification Action Guide
Why?	**STEP 2** ***SORT:*** identify stratification criteria (clinical conditions + more); weight **STEP 3** ***STRATIFY:*** patients to segment into target groups	Getting Started with Risk Stratification Video
How?	**STEP 4** ***DESIGN:*** care models and target interventions for each risk group	

Risk Stratification

WHAT
is risk stratification?

Segmenting your patients into distinct groups of similar complexity and care needs to better target care and services.

Risk groups commonly include:

- Highly complex
- High risk
- Rising risk
- Low risk

Risk Stratification

WHY
Risk stratify?

At the population level

Create care models matched to the needs of population subgroups

At the individual level

Assign a risk level and customize care and services within risk level

Risk Stratification

Step 1:
COMPILE a list of health center patients

Build on your Empanelment work:

- Run reports by each PCP or PCP team
  - Include established health center patients
  - Include payer attributed patients who may not have had a visit yet.

Develop processes for integrating payer data and provide outreach to patients to engage in care!

Step 2:
SORT: Identify risk stratification criteria

Identify the criteria to include in your risk stratification process:

- Consider reporting capabilities of your electronic health record and population health management system
- If your systems allow, use multiple criteria for a comprehensive approach
- If your systems don't allow consideration of multiple criteria – start with clinical conditions; do a 'simple' condition count!

Criteria to consider:

Clinical conditions (diagnosis)
Social risk factors
Utilization data (hospitalizations, ED visits)
Clinical lab values
High risk medications

Step 2:
SORT: Assign each criterion a weight

Clinical Conditions

- HRSA's Uniform Data Systems (UDS), Table 6A, is a great list to work from.
- Represents high cost, cost prevalence conditions among health center patients
- Health centers already collecting data, and reporting on, these measures
- Add or subtract from list based upon local health conditions, patient populations, and clinical priorities

Example

Diagnostic Category	Applicable ICD-10-CM Code	Criterion Weight
Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	2
Chronic lower respiratory diseases	J40 (count only when code U07.1 is not present), J41- through J44-, J47-	2
Asthma	J45-	2
Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	3
Hypertension	I10- through I16-, O10-, O11-	2
Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	2
Depression and other mood disorders	F30- through F39-	2

Health center determines criteria and weighting

Step 2:
SORT: Assign each criterion a weight

Social Drivers of Health

Consider using Qs within NACHC's PRAPARE tool: **www.prapare.org**

Assign weight to the question responses that indicate social risk

Example

Response to PRAPARE Question	Criterion Weight
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)	1
Yes (lack of transportation), has kept me from medical appointments	1
No (I do not feel physically and emotionally safe where I currently live)	2
Yes (I am a refugee)	3

Health center determines criteria and weighting

Step 2:
SORT: Assign each criterion a weight

Clinical Lab Values

In addition to looking at clinical diagnosis, lab values can be included into the risk stratification process to incorporate data on a patient's level of disease management.

Example

Clinical Lab Values	Criterion Weight
A1C > 9	2
Blood pressure > 140/90 mmHG	3
Total cholesterol > 240 mg/dl	1
Triglycerides > 500 mg/dl	1

Health center determines criteria and weighting

Step 2:
SORT: Assign each criterion a weight

Medications

Medications can also be included in the risk stratification process.

Determine which medications your health center considers to be high risk.

Example

High Risk Medications	Criterion Weight
Opioids	4
Benzodiazepines	4
Anticoagulants	4
Antipsychotics	4
Insulin	2

Health center determines criteria and weighting

Step 2:
SORT: Assign each criterion a weight

Utilization Data

If available, utilization data (e.g., hospitalizations and ED visits), provides a more comprehensive understanding of patient risk factors outside the walls of your health center.

Example

Utilization Criterion	Criterion Weight
1-2 hospitalizations within the last year	2
2-3 hospitalizations within the last year	3
4 + hospitalizations within the last year	4
1-2 ED visits with the last year	2
2-3 ED visits with the last year	3
4 + ED visits with the last year	4

Health center determines criteria and weighting

Step 2:
SORT: Assign each patient a total risk score

Using the lists of patients compiled in Step 1, assign each patient a **total risk score** representing each criterion the patient meets.

Examples:

Patient A

Criterion	Criterion Weight
Heart disease (selected)	2
Asthma	2
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)	1
4 + ED visits with the last year	4
Total Risk Score	**9**

Patient B

Criterion	Criterion Weight
Diabetes mellitus	3
Overweight and obesity	2
Yes (lack of transportation), has kept me from medical appointments	1
1-2 hospitalizations within the last year	2
A1c > 9	2
Total Risk Score	**10**

Step 3:
STRATIFY: Assign patients into target groups

Arrange patients from highest risk score to lowest risk score.

This can be done for the overall population or provider panel, depending on size of your health center.

Risk Level	Total Risk Score *(Example)*	Estimated % patient population
Highly complex	>20	5-10%
High Risk	11-20	20-30%
Rising Risk	2-10	40-50%
Low Risk	0-1	10-20%

Patient Name	Risk Score	
Patient A	22	**Highly complex**
Patient B	18	
Patient C	16	**High risk**
Patient D	12	
Patient E	10	
Patient F	9	
Patient G	5	
Patient H	5	**Rising risk**
Patient I	4	
Patient J	3	
Patient K	3	
Patient L	2	
Patient M	1	
Patient N	0	**Low risk**
Patient O	0	

Remember: *Risk groups are a tool for targeting services, they are not a clinical diagnosis.*

Step 3:
STRATIFY: Seek provider & care team input

- **Seek input from provider & care team** on the patients assigned to each risk group
- **Add the patient's risk group** to their electronic health record, for care team members to easily view
- **Determine staff roles & responsibilities** based upon care models for each risk group (Step 4) and available staff resources

Step 4:
DESIGN care models and target interventions for each risk group

HIGHLY COMPLEX

Multiple complex conditions; could include psychological condition(s).

Requires intensive, pro-active care management

Goals: prevent high-cost emergency or acute care services

HIGH RISK

Multiple risk factors or conditions.

Requires structured care management and one-on-one support

Goals: chronic care management and preventive services

RISING RISK

One or several risk factors or conditions; moves in and out of stability.

Focus is on managing risk factors more than disease conditions.

Goals: identify and manage risk factors

LOW RISK

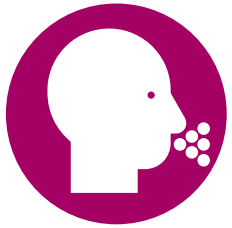
Few or no risk factors. Stable or healthy.

Focus is keeping patients engaged in the health care system without use of unnecessary services.

Goals: maintain connection; support health

Steps 1-4:
REPEAT process routinely

Repeat risk stratification process routinely to capture newly empaneled health center patients, including attributed patients where possible:



patient diagnosis

social risk factors

utilization data

lab values

high-risk medications