KENNEBEC REGION HEALTH ALLIANCE

POPULATION HEALTH MANAGMENT

TOPIC: RISK STRATIFICATION PROCEDURE
IMPLEMENTATION DATE: 6/27/19

AUTHORIZATION:

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I. PURPOSE: To define a process of identifying patients who may benefit from care management based on a combination of utilization reports, payer reports, and medical record review in an effort to improve care coordination and to ensure cost-effective use of healthcare services.

II. GOAL/EXPECTED OUTCOME: A designee from each primary care practice, as assigned by the Practice Administrator, will review reports and the primary care medical record to identify the patient's risk category and take action steps to address those risks.

III. PROCEDURE: At a minimum of monthly the primary care practice teams will review reports and the medical record to identify patients that may be at increased risk according to the following criteria:

A. **Risk Identification**

1. **Very High or High risk (one or more of the following)**:
   - Hospital Admissions
     a. 3 or more admissions in past 6 months
   - Emergency Department Utilization
     a. 4 or more E.D. visits in past 3 months
   - Members identified by HealthInfoNet Analytics or other risk stratification tool as high-risk or high-cost
   - Polypharmacy: members using 5 or more daily medications, and/or on multiple high-risk medications (e.g. insulin, warfarin, benzodiazepines, opiates, etc.)
   - High social service needs that interfere with care: Eligible members who also have significant social service needs that result in high rates of avoidable utilization of medical services (e.g. members who are homeless, have an intellectual disability, substance use, food insecure).
   - High gaps in care, or poorly controlled chronic conditions (e.g. COPD, CHF, diabetes, asthma)
2. **Moderate risk**: A high number of gaps in care may indicate moderate risk. Patients with a lower risk score, but with a chronic condition (e.g. COPD, CHF, diabetes, asthma), may prompt the need for a care plan to prevent future complications or costs.

3. **Low risk**: Patients who have care needs that, if left untreated, could result in higher cost and/or utilization, with decreased quality of health and life. These patients may be identified with lower gaps in care or risk scores, or through other methods within your practice.

B. **Practice Preparation for general outreach to patients**
   1. Review medical record to confirm risk identifiers
   2. Confirm last office visit and determine who saw the patient and for what service(s)
   3. Consider Very High or High Risk patients for referral to Community Care Team
   4. Consider Moderate or Low Risk patients for Practice Care Management

C. **Care Management Assessment and Outreach**:
   1. Assess understanding of injury, illness, or condition
   2. Review medication adherence
   3. Schedule, if needed, a follow-up appointment with a PCP
   4. Complete a care or treatment plan, if appropriate
   5. Develop a Self-Management Action Plan, if appropriate
   6. Refer to appropriate agencies to address social service needs

D. **Practice Post-discharge Outreach:** if the patient has been discharged from an inpatient stay or the Emergency Department, the practice team will make their best effort to complete the following in 48 hours:
   1. Assess understanding of injury, illness, or condition
   2. Review discharge instructions and follow-up plan
   3. Reconcile the patient's discharge medication list and confirm with the patient that new prescriptions have been filled
   4. Confirm follow-up appointment with PCP
   5. Review signs of deterioration and the patient's action plan
   6. Provide instructions on how to access care after hours
   7. Consider referral to the Community Care Team or Practice Care Management if appropriate for additional assessment and outreach as noted above

IV. RESPONSIBILITY:

A. Practice designated staff will review the chart and make contact with patients or make appropriate referrals to care managers and document in the medical record.