NH BEHAVIORAL HEALTH INTEGRATION LEARNING COLLABORATIVE

Focused Care: Using Risk Stratification Tools to Optimize Patient Care

February 6th, 2019
REMINDERS

FOR ZOOM CALLERS

Enter audio code when using both computer and phone for better audio quality for all.

Please note your name, then add your comment or question

FOR IN-PERSON ATTENDEES

Please speak towards the microphones

Use the Zoom Mute, Start/Stop Video, and Chat Box if needed
WELCOME

FELICITY BERNARD, LCMHC
Project Director, NH Citizens Health Initiative
INTRODUCTION TO UTILIZING RISK STRATIFICATION IN THE PRACTICE SETTING
Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative

HOW TO GET THE MOST VALUE OUT OF TOOLS/PROCESSES IMPLEMENTED
Stephanie Cameron, MPH, NH Citizens Health Initiative

RISK STRATIFICATION IN PRACTICE
Tracy Tinker, RN, MSN, CDE, CDL, Catholic Medical Center

PAYMENT FOR UTILIZING RISK STRATIFICATION APPROACHES
Dee Watts, LSSBB, NH Citizens Health Initiative

QUESTIONS & ANSWERS
Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative

CLOSING REMARKS
Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative
PLANNING & PRESENTER DISCLOSURES

The following individuals have responded that they have nothing to disclose:

- **Planner: Kelsi West, BS, Research Associate**, Institute for Health Policy and Practice, UNH
- **Planner: Frederick Kelsey, MD, FACP, retired Medical Director**, Mid State Health Center
- **Planner: Annie Averill, BA, Research Associate**, Institute for Health Policy and Practice, UNH
- **Planner: Janet Thomas, ADRN, BS Project Director PTN**, Institute for Health Policy and Practice, UNH
- **Planner & Presenter: Felicity Bernard, LCMHC, MA Project Director**, Institute for Health Policy and Practice, UNH
- **Planner & Presenter: Stephanie Cameron, MPH, Project Director**, NH Citizens Health Initiative
- **Planner: Laura Remick, MEd, CHES**, Education and Workforce Coordinator, North Country Health Consortium
- **Planner: Jill Gregoire, RN, MSN, Lead Nurse Reviewer**, North Country Health Consortium
- **Planner: Mitch Sullivan, MD, Lead CME Physician Reviewer**, Coos Family Health Services
- **Presenter: Delitha Watts, LSSBB, Practice Transformation Facilitator**, Institute for Health Policy and Practice, UNH
- **Presenter: Tracy Tinker, MSN, CDE, CNL, Case Manager, QI and Chronic Disease Coordinator**, Diabetes Resources Institute at Catholic Medical Center
LEARNING OBJECTIVES

After participating in this activity, learners will be able to:

Describe the value of risk stratification and registries for population health management in clinics providing integrated behavioral and primary care.

Understand potential risk stratification approaches for identifying high-risk patients served in integrated care.

Recall lessons learned about applying risk stratification algorithms to support population health management through case studies of local integrated care clinics.
Question: What is your level of involvement with Risk Stratification?

- We have a tool embedded in our EHR and actively use it to manage patients
- We have a tool outside of our EHR and actively use it to manage patients
- We have a tool, but currently do not utilize it to manage our patients
- We do not have a tool, but would like to implement one
- We have not considered risk stratification in our organization
INTRODUCTION TO UTILIZING RISK STRATIFICATION IN THE PRACTICE SETTING

FELICITY BERNARD, LCMHC
Project Director, NH Citizens Health Initiative
For every 1,000 patients in a panel...

- 20% could benefit from more intensive support
- 80% of the total health care spending in the US
- 5% account for nearly 1/2 of U.S. Health Expenditures

Triple Aim:

- Patient experience of care
- Health of populations
- Reduce cost
What is it?

- Predict
- Prioritize
- Align treatment with need
Why do it?

Value Based Payments
Prevention
Data-driven decision-making
Risk is dynamic, not static

Alignment with Value-Based Payments

- Value-Based Services
- Clinical Quality Outcomes
- Population Health Management
- Risk Stratification

Concepts are not loosely linked--but are structurally contingent on one another

Risk Stratification
Examples of Risk Stratification Methods

• Hierarchical Condition Categories (HCCs)

• Adjusted Clinical Groups (ACG)

• Elder Risk Assessment (ERA)

• Chronic Comorbidity Count (CCC)
Getting started...

Start small, 3 or 4 data points - Grow as comfort level grows

• **Step 1**  Compile a list of patients

• **Step 2**  Sort patients by condition

• **Step 3**  Stratify patients to segment the population into target groups based on the number of conditions per patient

• **Step 4**  Design care models and target interventions for each risk group

Examples

• Care Transitions Network Risk Stratification Tool
  ✓ Enables providers to stratify risk, identify trends, and track outcomes over time at the population level

• CCSA adapted from Aims Center
# Risk Stratification Tool with BH Focus

## The National Council

## Care Transitions Network

This workbook is used to examine the stratification of risk in your client population. To use it properly:

1. Enter raw data from your EHR into columns A-K of the 'raw data' tab. Make sure your columns are in the correct order and your fields conform to the field requirements listed in row 3 of the 'raw data' tab.

2. Enter data into columns L-P of the 'raw data' tab.

3. Do not enter anything into column Q of the 'raw data' tab. This column is calculated.

At this point the 'summary data' tab is populated. If you wish to perform further analysis, we recommend creating pivot tables using the information in the 'transformed data' tab.

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### CCSA Registry/Stratification

| A  | B  | C   | D  | E   | F   | G   | H | I  | J  | K  | L   | M  | N  | O   | P                                                |
|----|----|-----|----|-----|-----|-----|---|---|---|---|-----|----|----|-----|                                                  |
| Date | WKN | First Name | Last Name | Treatment Status | Date Contacted | Type of Contact | Date Follow Up Due | PHQ-9 Score | PHQ-9 Score | GAD-2 Score | GAD-7 Score | Alcohol or use non-prescribed drugs? If yes, why? | CASR | Caregiver needs help reading or understanding your health information? | What is your housing situation today? (check one) |
| 1/7/2018 | 20319 | Bob | Doe | Active | 1/2/2018 | In Person | 12/1/2018 | 4 | 3 | 3 | 3 | No | Yes | No | I have housing that is safe and adequate |
| 12/3/2018 | 2156 | John | Doe | Inactive | 10/2/2018 | Other (specify) | 12/1/2018 | 4 | 2 | 3 | 3 | No | Yes | No | I do not have housing (I am couch-surfing, in a motel, living on the street, in a car, an abandoned building) |

**Situation, do you have issues with any of the following? (check all that apply)**

- Somewhat hard
- No
- No
- No
- Attended school
- No
- No
- No

- Somewhat hard
- Yes, a lack of transportation has stopped me from going to work, appointments, meetings or getting things that I need for daily living.
- No
- I have transportation

**Legal issues that are getting in the way of your health or healthcare?**

- Yes
- No

**Currently receiving help for any needs mentioned in the last column?**

- No
- Yes

**Do you have someone you could call if you need help or a favor?**

- No
- Yes

**What additional need(s) do you have that is not addressed above?**

- Bob needs follow up
- John will need follow up

**MDCT Date**

- 5
- 3

**Risk Score**

- 5
- 3
From the field…

“The Patient Centered Assessment Method, PCAM, is a tool medical practitioners can use to assess patient complexity using the social determinants of health ... the final section focused on the actions that can be taken.”
http://www.pcamonline.org/about-pcam.html

“AIMS center tool can be very helpful”
https://aims.uw.edu/resource-library/patient-tracking-spreadsheet

“Johns Hopkins ACG Risk Stratification scoring 1-5. Works very well and it is incorporated in our population health software, which is connected to our EMR, NextGen”
https://www.hopkinsacg.org/
HOW TO GET THE MOST VALUE OUT OF TOOLS/PROCESSES IMPLEMENTED

STEPHANIE CAMERON, MPH
Project Director, NH Citizens Health Initiative
Putting it into Action: Planning

Identify your pilot team, including a clinical champion

Determine project team roles and communication strategy (Charter)

Clarify your project aims and measures

Map out the process and create a plan for implementing

Conduct Plan-Do-Study-Act (PDSA) cycle

Quality Improvement Worksheet

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<tr>
<th>Practice Name:</th>
<th>Project Owner:</th>
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<table>
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<td>END DATE:</td>
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<tr>
<td>TRACKER:</td>
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<tr>
<td>TEAM MEMBERS:</td>
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Global Aim
Create an aim statement that will keep your focus clear and your work productive. What are we trying to accomplish? What is the overarching goal?

Specific Aim
Use numerical goals, specific dates, and specific measures. What is the area of focus?

Measures
How will we know that a change is an improvement? List measures to track for the project

PDSA
PLAN
How should we PLAN the pilot? Why? Does what? By when? What baseline data do we track?

DO
What are we thinking as we DO the pilot? What happened? Any obstacles, roadblocks, surprises?

STUDY
Are we STUDYing what happened, what have we learned? What did the measures show?

ACT
Based on our results, how will we ACT? 1) Reteest with a modified plan, 2) extend to a larger test group, 3) abandon altogether, 4) adopt the new pilot and monitor. Make a PDSA for the next cycle of change.

[Footer information]
Putting it into Action: Implementing

• Utilize data to help determine a pilot patient population.

• Determine which platform is best for your organization:
  • EHR
  • Outside tool (Excel spread sheet, software platform)

• Ensure the components (behavioral health screens, SDoH, chronic medical disease) you are tracking support your global and specific aims.

• Have an early discussion on how you will address the findings of the data.

• Identify someone on your clinical team who will be responsible for tracking and analyzing the data (behavioral health clinician, nurse care manager, other).
Putting it into Action: Study and Action

- Determine who your highest need patients are
- Develop a criteria for identifying these patients
- Implement a concrete way the treatment providers can address the high-risk patients (huddles, case reviews, etc.)

Patient Level

- Identify if there is a common theme
- Are there possible next steps to address these themes?

Population Level

- Determine if there are other components that need to be captured
- Are there particular processes that need to be changed or developed?

Quality Improvement
RISK STRATIFICATION IN PRACTICE

TRACY TINKER, RN, MSN, CDE, CNL
Chronic Disease and Quality Improvement Coordinator and Certified Diabetes Nurse Educator, Catholic Medical Center
Risk Stratification

Matt Augeri
Tracy Tinker, RN, MSN, CDE, CNL
Risk Stratification Model

- **Tier 4**
  - Highest Risk
  - High Utilizer of ED/Multiple hospital admissions and/or 3 other risk factors

- **Tier 3**
  - High Risk
  - 3 risk factors or 2 risk factors with a chronic disease which is not controlled

- **Tier 2**
  - Medium Risk
  - 2 risk factors or 1 risk factor with acute disease or chronic disease controlled

- **Tier 1**
  - Low Risk
  - 1 risk factor or chronic disease controlled or preventive care* only
High Risk

- High utilizer of the ED/Multiple admissions – > 3 times in a year (weighted as a 2)
- Housing status – Street (tent or car or outside) (weighted as a 2)
- Substance use disorder current or history within 1 year – active (Audit or DAST scores) (weighted as a 1)
- Behavioral Health diagnosis (Bipolar Disorder, Schizophrenia, Schizoaffective Disorder, Anorexia Nervosa Disorder, Major Depressive Disorder) – active (weighted as a 1)
- Chronic disease uncontrolled (Diabetes with A1C > 9; Hypertension with BP > 140/90; COPD on 3 or more controller medications) (weighted as a 1)
- Frequent no show of appointments (5 or more) (weighted as a 1)
- Process for outside referrals and practice staff – referred clients are risk stratified using the above established HCH criteria (weighted as a 1)
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### Self Management Goals

#### Goal #1: Last updated: 12/04/2018
- Reviewed - no changes required
- Add an additional day of walking

#### Goal #2: Last updated: 10/28/2018
- Reviewed - no changes required

#### Goal #3: Last updated: 12/04/2018
- Reviewed - no changes required

Add healthier protein food at breakfast. Tracy Tinker RN December 13, 2018 4:31 PM

Barrier Goal 3: Prefers eggs and sausage and bacon
- Motivation 3: Discussed diabetes with friends wishes to keep control
- Action Plan 3: Add protein at breakfast
- Stage of Change: Action
Future Goals

- Run model more often than 6 months
- Integrate with EMR
- Meet with Clinical Team to redefine risk factors
"I think that health care is more about love than most other things. If there isn’t at the core of this two human beings who have agreed to be in a relationship where one is trying to relieve the suffering of another, which is love, you can’t get to the right answer here"
PAYMENT FOR UTILIZING RISK STRATIFICATION APPROACHES

DEE WATTS, LSSBB
Practice Facilitator, NH Citizens Health Initiative
Question: Does your organization currently use Chronic Care Management (CCM) codes or Collaborative Care Model (CCoM) codes?

- Yes, chronic care management codes
- Yes, collaborative care model codes
- Both
- None
- Unsure
Revenue Opportunities for High Risk Patients

• **Chronic Care Management (CCM)**
  Billable codes for high risk patients with more than 2 chronic health conditions

• **Collaborative Care Model (CCoM)**
  Billable codes for high risk patients with more than 2 chronic health conditions that also requires psychiatric collaboration
Care Team Definitions

- **Treating Provider**: Primary Care Provider or other non-physician practitioners including Nurse Practitioners. Physician Assistants are included if billing under a supervising provider.

- **Clinical Support Staff**: Employees working under the Treating Provider, subject to State law, licensure and scope of practice.

- **Behavioral Health Care Manager**: The care manager should be selected based on the clinical skills needed; there are currently no defined credentials for this.

- **Psychiatric consultant**: They do not have to be an employee, but should have an established contract with the physician or group.
Chronic Care Management

**99490**
- Care coordination for 2 or more chronic conditions.
- 20 minutes of clinical staff time directed by a physician, or other qualified healthcare provider, per calendar month.

**99484**
- Care coordination for 2 or more chronic conditions with at least one being related to behavioral health.
- 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional per calendar month.

**99487**
- Care coordination for 2 or more chronic conditions.
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

**99489**
- Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
Collaborative Care Model

99492 (formerly G0502)
• Including collaboration with a psychiatric consultant.
• 70 minutes in the first calendar month for behavioral health care manager activities as directed by the treating provider.

99493 (formerly G0503)
• 60 minutes in a subsequent month for behavioral health care manager activities.

99494 (formerly G0504)
• Each additional 30 minutes in a calendar month of behavioral health care manager activities.
Tips and Hints

Must Include
• 2 or more chronic conditions expected to last 12 months or more
• Prior Annual Wellness Exam or Comprehensive E/M
• Documented patient consent
• Comprehensive Care Plan
• Time tracking method

Cannot Bill in the Same Month As
• Transition Care Management
• Home Healthcare Supervision
• Hospice Care Supervision
• Certain ESRD Services
QUESTIONS & ANSWERS
CLOSING REMARKS
Resources


- **Measurement-Based Treatment to Target | University of Washington AIMS Center.** (n.d.). Retrieved December 14, 2018, from https://aims.uw.edu/resource-library/measurement-based-treatment-target

Resources Continued


# STAFF CONTACT INFORMATION

<table>
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<tr>
<th>Name</th>
<th>Email</th>
<th>Name</th>
<th>Email</th>
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<tbody>
<tr>
<td>Annie Averill</td>
<td><a href="mailto:annie.averill@unh.edu">annie.averill@unh.edu</a></td>
<td>Sally Minkow</td>
<td><a href="mailto:sally.minkow@unh.edu">sally.minkow@unh.edu</a></td>
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<tr>
<td>Felicity Bernard</td>
<td><a href="mailto:felicity.bernard@unh.edu">felicity.bernard@unh.edu</a></td>
<td>Molly O’Neil</td>
<td><a href="mailto:molly.oneil@unh.edu">molly.oneil@unh.edu</a></td>
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<tr>
<td>Stephanie Cameron</td>
<td><a href="mailto:stephanie.cameron@unh.edu">stephanie.cameron@unh.edu</a></td>
<td>Jeanne Ryer</td>
<td><a href="mailto:jeanne.ryer@unh.edu">jeanne.ryer@unh.edu</a></td>
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<td>Kate Cox</td>
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<td>Hwasun Garin</td>
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<td>Kelsi West</td>
<td><a href="mailto:kelsi.west@unh.edu">kelsi.west@unh.edu</a></td>
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CONTACT US

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www.citizenshealth initiative.org

SEND US A NOTE
info@citizenshealth initiative.org