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Risk Status Assignment Practice Implementation Guide

What is risk stratification and how does it relate to population health management at the practice level?

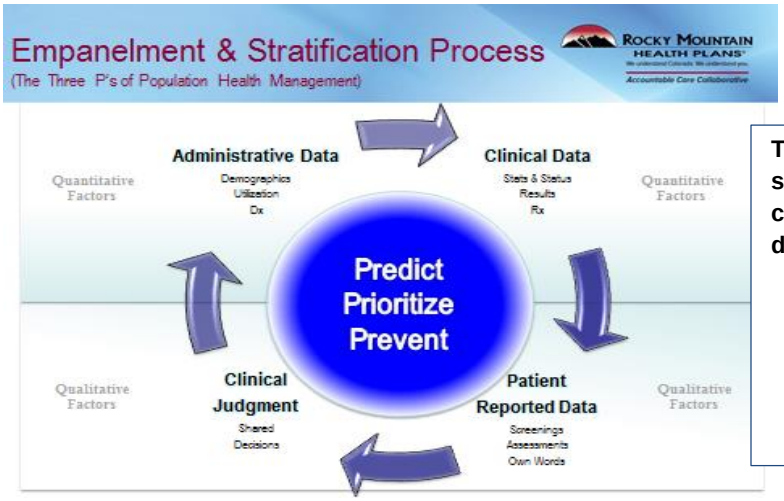
According to Asaf Bitton, MD, MPH, FACP*: Risk stratification is an intentional, planned, and proactive process carried out at the practice level to effectively target services to patients. It represents a move from a *reactive* single physician to a more *proactive* team of providers to address the total health needs of the total population of patients. While there isn't a perfect way to stratify risk, it responds to the question, "*How do we keep our sickest patients from getting sicker?"*

Why is risk stratification important?

Dr. Bitton: When practices take the data they've generated and use it to segment the population into tiers of risk, they can then target finite care coordination and care management services. Care management can be provided by dedicated care managers, or by existing staff to perform elements of these key roles. These care management services are often associated with improved patient outcomes and reduced utilization. That's the goal here – to provide patients with the best care possible by a variety of professionals working together to leverage their unique skills.

There's more than one way to get there:

A practice can approach the risk stratification process a number of ways – based on available practice resources that can be assigned to this ongoing task. Whenever possible, it is best to utilize data as the starting point of the practice's risk stratification method.



The final list of patients with risk status assignment should consider the 4 points in the diagram to the left:

1. **Administrative Data**
2. **Clinical Data**
3. **Patient Reported Data**
4. **Clinical Judgment**

Three common risk stratification methods:

1. Assigning score by patient's condition AND severity of condition (controlled/uncontrolled)
2. Assigning risk status based on number of chronic conditions (see diagram on next page)
3. Assigning high-risk patients based on provider's knowledge of their patient panel/provider gestalt

Patient examples:

- Low risk: A 40-year old female who comes in every two years for her physical exam and is due for a mammogram
- Medium risk: A 59-year old male who has diabetes and was recently hospitalized for kidney stones
- High Risk: A 62-year old female with a BMI >31, hypertension, diabetes, and depression, and was recently hospitalized for chest pain

Provider roles/responsibilities:

- Reviews patient list sorted by risk status assignment
- Provides edits/updates to Risk Status Manager
- Uses clinical judgment to apply risk status edits. As an example, to assign high-risk status to appropriate patients, the provider asks him/herself: "Which patients would I expect to be hospitalized or die in the next year?"

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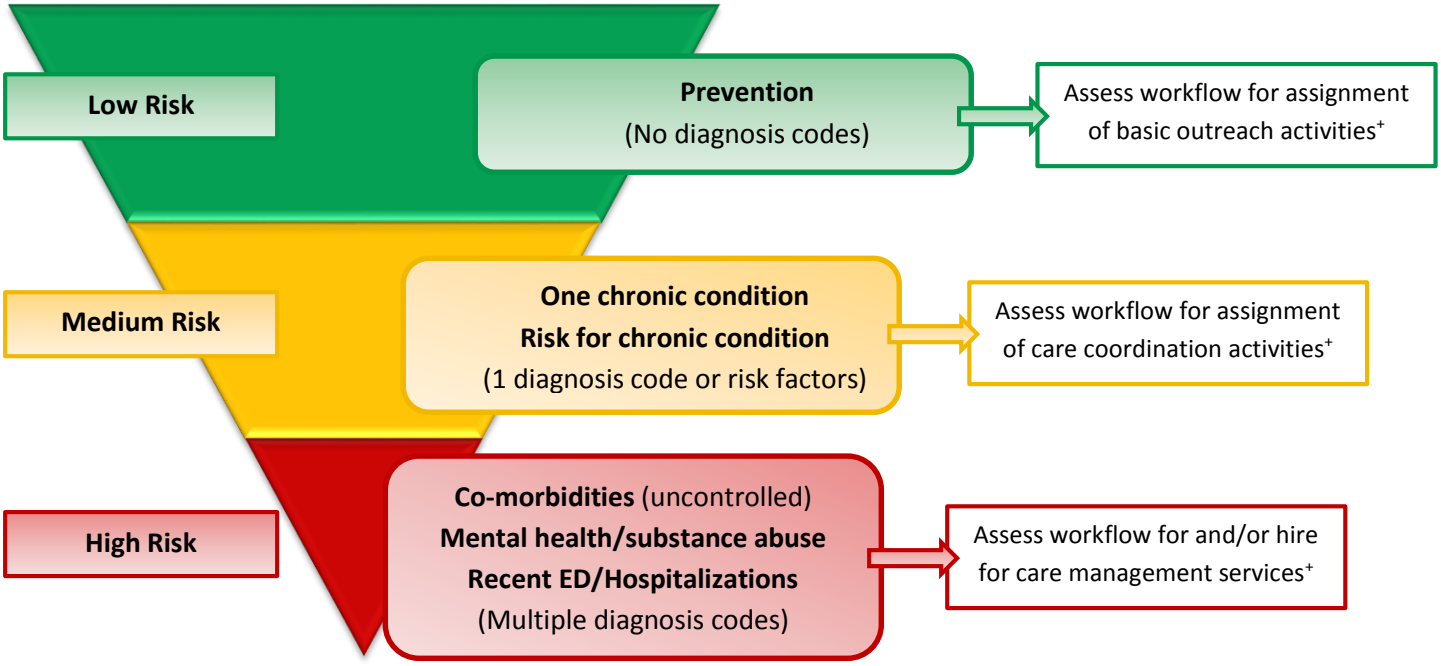
*A sample method for risk stratification***



Strategy for initial assignment of risk process

- Identify Risk Status Manager to:
  - Pull reports by provider for:
    - Patients with no diagnosis codes – assign low-risk status
    - Patients with risk factors – assign medium-risk status
    - Patients with diagnosis code(s):
      - Single diagnosis code: assign medium-risk status
      - Multiple diagnosis codes (uncontrolled): assign high-risk status
  - Review health plan data, as available
  - Start now with what you have!
  - Evaluate HIT resources to pull necessary reports from the practice EHR (see below)

Documentation ideas for risk assignment – consider what documentation effort leads to easiest reporting

- Existing EHR location for risk status assignment – there may be a risk stratification module available in the program or as an add-on
- Use Dummy Diagnosis Code (i.e., 001 = low, 002= mod, 003 = high)
- Create customizable discrete data field for risk assignment

Other considerations

- QI Team determines workflow for patient-reported information related to own risk status – update at the time of the visit (e.g., social supports, finances, community resources, etc.)
- Care Manager can:
  - run at least quarterly reports on the medium- and high-risk patient list to ensure service allocation
  - check hospital and ED visit list daily, if available, and consult with provider to adjust risk status as appropriate
- Integrate assessment of risk status into the workflow at each visit

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***Adapted from Colorado Consortium Newsletter*

+Document process/job descriptions