Risk Stratification: Using Data to Drive Clinical, Operational and Financial Decisions

March 15, 2018
2:00 – 3:00pm ET
Webinar Login Directions

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Learning Objectives

By the end of this webinar, participants will understand how to:

• Define population health management and risk stratification

• Analyze and ask the most pertinent and relevant questions about their patient populations

• Develop a risk stratification algorithm using indicators that effectively identify high-risk patients
Presenters:

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Aligning Our Terms!

PPS payment requires...

Care Management requires...

Population Health Management requires...

Risk Stratification & Care Coordination which requires...

Understanding Clinical, Satisfaction & Financial Data...

Therefore VBS addresses both Effectiveness & Efficiency

These concepts are not loosely linked but are structurally contingent on one another and must be fully expressed in the Care Pathway...
A small portion of our patient population are high utilizers of our hospital systems.

High utilizers are not receiving treatment that is effectively impacting their disease state.

High utilizers have a tremendous cost impact on the system.

Need a methodology to identify these high risk clients and systematically target improved wellness.
Numerator & Denominator

Numerator = The count of instances that the issue under review happened
- 23 people have a PHQ-9 score over a 15

Denominator = the entire population under review
- 100 people were assessed using the PHQ-9
Types of Metrics

**Process Measures** explain how the system works
- % of patient population who received a PHQ-9 assessment in the last 90 days
- % of high risk patient population who were seen in the last two weeks

**Outcome Measures** explain the effectiveness of the system
- % of patient population who had an inpatient stay in the past 6 months
A Metric Accurately Reflects Work If…

- **ACTIONABLE**
  - When metric changes the cause & required actions are clear

- **ACCESSIBLE & CREDIBLE DATA**
  - Data can be collected with modest effort from source that is trusted

- **COMMON INTERPRETATION**
  - Staff know what the metric means

- **TRANSPARENT & SIMPLE TO CALCULATE**
  - Method for generating metric is shared & well understood
Audience Poll

What are some of the indicators you are using to identify risk?
Risk Stratification and CCBHCs

- Demonstration of National Council Risk Stratification Tool tailored for CCBHCs
- Chronic behavioral health conditions
  - Depression and anxiety
  - Substance use disorder
  - Bipolar disorder
  - Trauma and stressor
  - Schizophrenia
- Date of last appointment
- Recent hospitalization or ED visit
- Medical co-morbidities
- Receiving MAT services
- Criminal Justice involvement
Potential Questions to Emerge When Mapping to Your EHR

• Is the data accurate?
• If the data is not accurate is this due to human error?
• How do I create a culture of learning?
• Do we need to train staff on workflow or re-examine workflow to ensure accurate data entry?
• If data is accurate, what does this say about our clinical interventions?
• Do we need to provide context and train staff on risk stratification?
• What policies and procedures do we need to create to support staff to correctly enter and utilize data?
Data, Information, & Knowledge

• What is data?
  Granular or unprocessed information

• What is information?
  Information is data that have been organized and communicated in a coherent and meaningful manner

• What is knowledge?
  Information evaluated and organized so that it can be used purposefully
Case Lifecycle

Intake

Policies & Case Lifecycle Procedures

Closeout

Sustainability
Identifying risk level at intake:

• Assessments
  – Psychosocial
  – PHQ-9
  – GAD-7
  – Alcohol Use Disorders Identification Test (AUDIT)
  – Medical
  – Criminal Justice

• EHR
  – Process/procedure to pull risk stratification data
  – Need discrete fields

• Referrals
  – MAT services
  – Recovery oriented treatment
  – Primary care
Sustainability

- Policies and procedures associated with each level of risk

- Risk level informs
  - Evidence-based interventions
  - Intensity of intervention
  - Care coordination
  - CARE PATHWAYS

- Natural re-assessment points
  - Treatment planning
  - Supervision
Closeout

• Risk stratification during closeout
  • Determine when and how to close a case
  • Reduction in risk level
  • Engagement in services outside of agency
  • Communication with external stakeholders about case closure
  • Considerations based on level of risk
Low Hanging Fruit—Call for Immediate Action!

- What is your algorithm to identify risk
- How do your clinicians understand the problem
- How will you collect this data
- Who will collect this data
- How will you disseminate this data
- What do your clients view as the biggest contributing factors
Population Health in Behavioral Healthcare Setting

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Staffing: Care Coordinators

- 2 Care Coordinators per CCBHC Setting
  - Coordinate care internally and external to the agency
  - Facilitate huddles
  - Supervised by Primary Care Clinic Director, but coordinate care across the health centers
  - Vitals and other health indicators
  - Referrals
  - Data entry into two EHRs
Population Health Analyst

- Understand demographics of client population
- Understand ED utilization and inpatient admissions
- Examine the influence of housing status on health outcomes
- Explore health disparities in gender, race, and socioeconomic status
- Explore the influence of behavioral and physical health diagnoses

How do mental health diagnoses predict a diagnosis of chronic pain among Cascadia’s clients?
Understanding our Population

- Also examined, hypertension, obesity, cardiovascular disease (CVD), and cancer diagnoses as outcomes:
  - **Hypertension**: PTSD (42% more likely), Bipolar 1 (52% more likely), Major Depressive Disorder (53% more likely)
  - **Obesity**: SUD Amphetamine (42% less likely), Schizophrenia (121% more likely), PTSD (56% more likely), Bipolar 2 (59% more likely), Major Depressive Disorder (64% more likely)
  - **CVD**: Schizophrenia (81% more likely), PTSD (29% more likely), Bipolar 1 (96% more likely), Major Depression (101% more likely)
  - **Cancer**: Depression (50 more likely), Alcohol (34% less likely)
Panel Management

• Working in multiple EHRs
• Pre-Manage/EDIE
• Panel development
• Cross agency (not specific to CCBHC programs)

• Services
  • Diabetic foot and eye exam
  • Blood draw
  • Specialty Referrals

• Outcomes
  • Controlled A1c
  • Reduction in hospitalization/ED usage
Risk Stratification- Where to Start

Identifying your population:
- Diagnosis (diabetes)
- Program (Housing Outreach Team, Ambulatory Detox)
- Service Utilization (reduction in ED/Hospitalization)
- Medication (due to risk factors/side effects)

Role of staff:
- Determine who manages the panel
- Determine which services and interventions to include in panel management

Data:
- Determine data sources
- Determine where data will be kept and how it will be organized
- Determine goals/outcomes/benchmarks
Get Help!

Peer Learning Network Participants

• Listserv Inquiries
  – ccbhc_cop@nationalcouncilcommunities.org

• CCBHC Resource Page
  – https://www.nationalcouncildocs.net/ccbhc-learning-community
Get Help!

Master Class Community of Practice Participants

CCBHC Resource Page
- https://www.nationalcouncildocs.net/ccbhc-learning-community

Sign-Up for Faculty Office Hours with Kate Davidson

- Thursday March 29th from 1:00-4:00p ET

Attend an Affinity Group Call
- March 26, 2018 at 2:00pm ET – Operations & Financial
- April 4, 2018 at 3:00pm ET – Clinical & Data/Quality
- April 12, 2018 at 2:30pm ET – Operations & Financial
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Webinars

April 18th 2:00pm EST
Register Here

May 18th 2:00pm EST
Register Here

CCBHC Resource Page  https://www.nationalcouncildocs.net/ccbhc-learning-community
Still Have Questions?

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