YOU ARE NOW FREE TO RISK STRATIFY YOUR POPULATION

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Welcome

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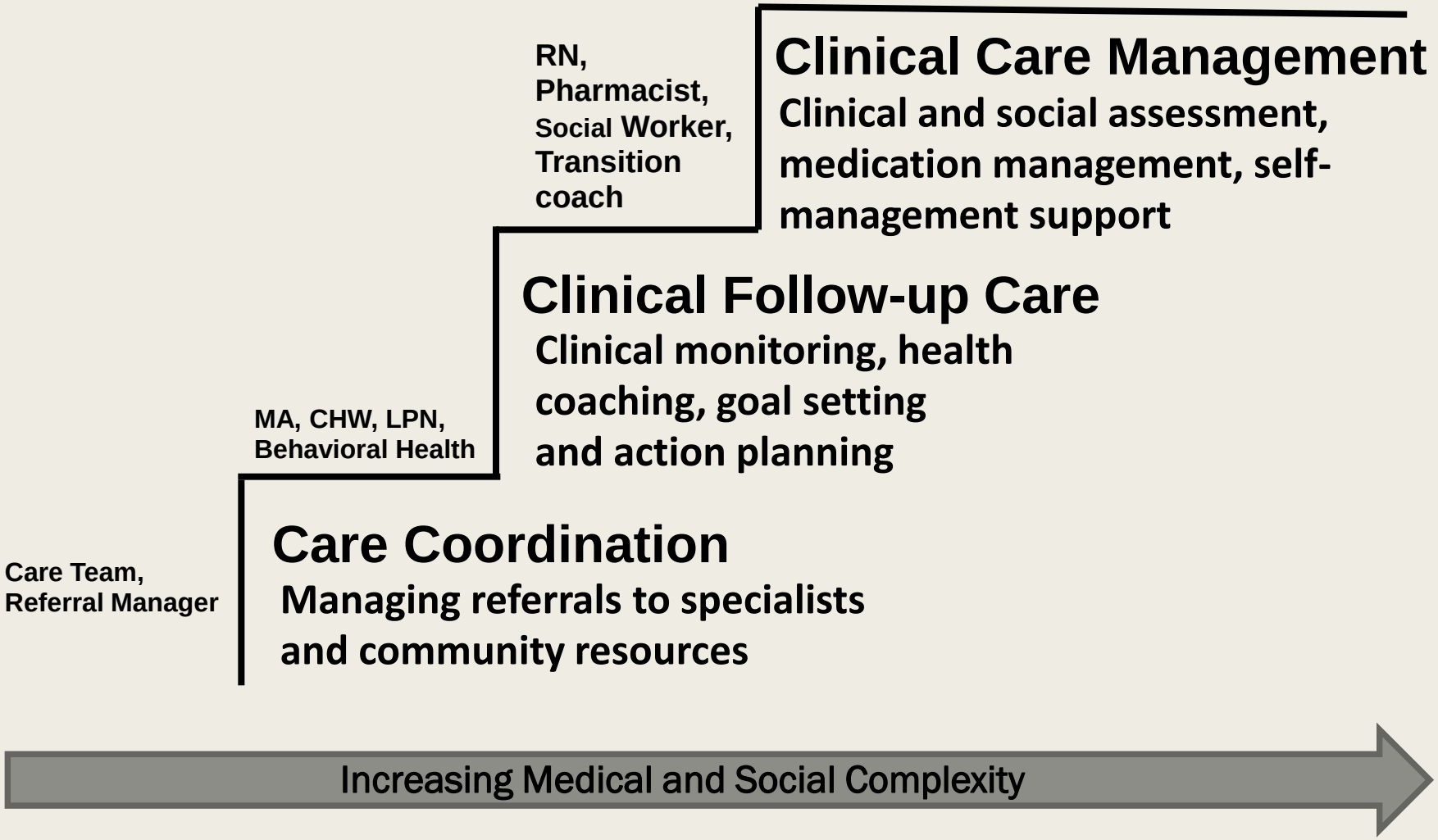
Objectives

- Learn about the value of risk stratification
- Learn about the different methods of stratification
- Where do you begin?

VALUE OF RISK STRATIFICATION

Large Population

Population Segmentation



Care Segmentation

- Each population segment needs something different
- Diabetics are different from asthmatics
- Different members on the care team
  - *Provider, RN, MA, Case Manager, Behavioral Health, Clinical Pharmacy, etc.*
- To be successful, you need to have the right skill sets working with the right groups
- One size does not fit all
- The same is true for risk groups

Value of Risk Stratification

- Managing patients with multiple chronic conditions and co-morbidities is becoming harder and harder
- Organizations need to better understand their populations in order to manage their resources
- Starting can be a bit daunting…

STRATIFICATION METHODS

Many different options

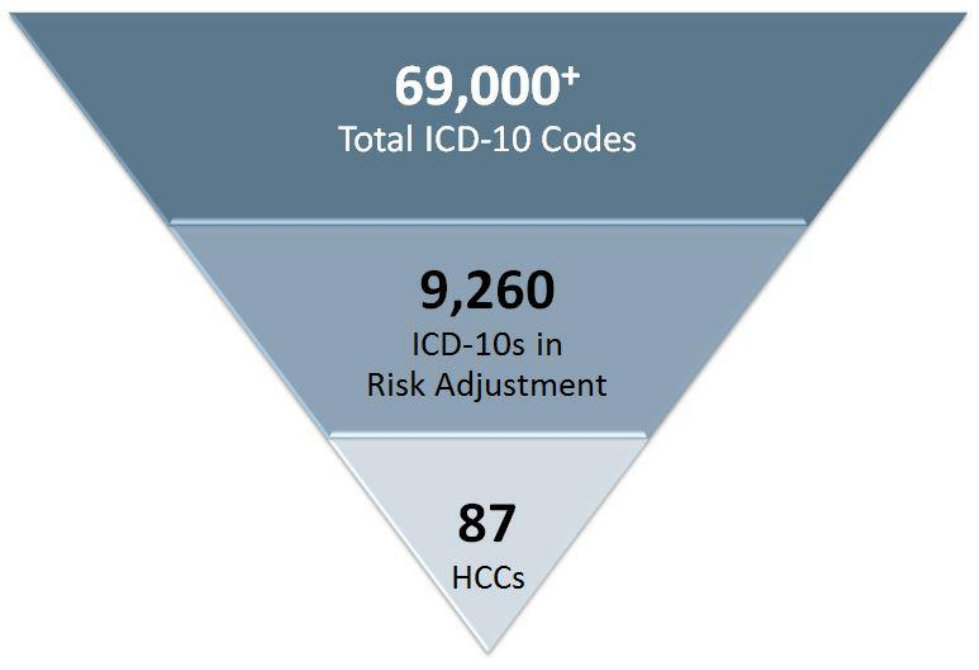
- Adjusted Clinical Groups
- Hierarchical Condition Groups
- Hotspotting
- Chronic Condition Counts
- Comorbidity indexing
- Questionnaires
- Hybrid models

Adjusted Clinical Groups (ACGs)

- Commonly used system based on administrative diagnosis data developed at Johns Hopkins
- Designed to predict utilization
- Patients classified into 1 of ACG buckets
- Can also help with inpatient hospitalization predictions

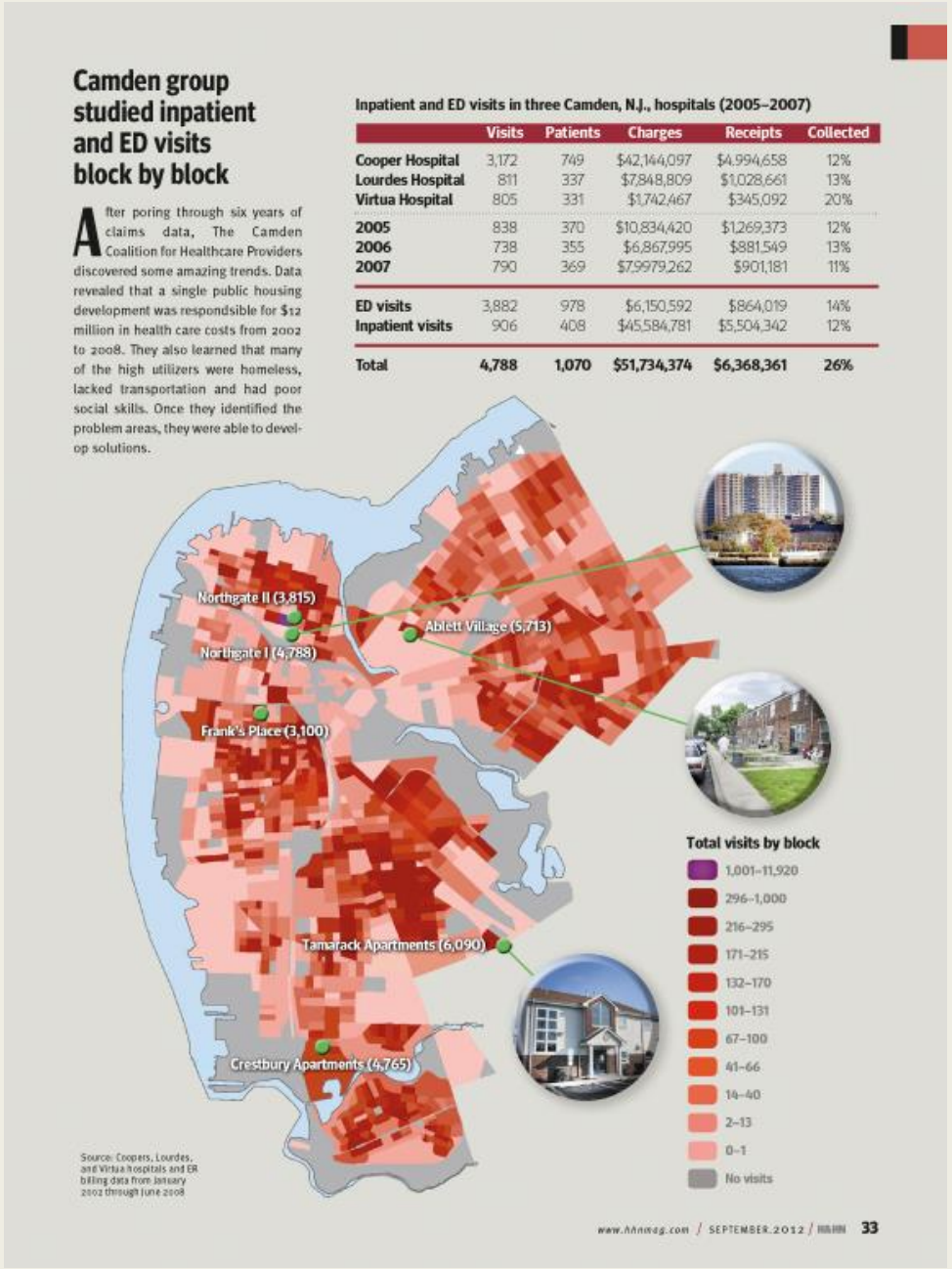
Hierarchical Condition Groups (HCCs)

- Designed by CMS to adjust Medicare capitation payments
- ICD codes and demographic data for each patient are aggregated into condition categories that contribute to a single risk score
- Can be used to predict hospitalizations



Hotspotting

- Camden Coalition
- Identification of extreme patterns in a defined region of the healthcare system
- Used to guide targeted intervention
- Data is typically hospital claims



Camden group studied inpatient and ED visits block by block

After poring through six years of claims data, The Camden Coalition for Healthcare Providers discovered some amazing trends. Data revealed that a single public housing development was responsible for $12 million in health care costs from 2002 to 2008. They also learned that many of the high utilizers were homeless, lacked transportation and had poor social skills. Once they identified the problem areas, they were able to develop solutions.

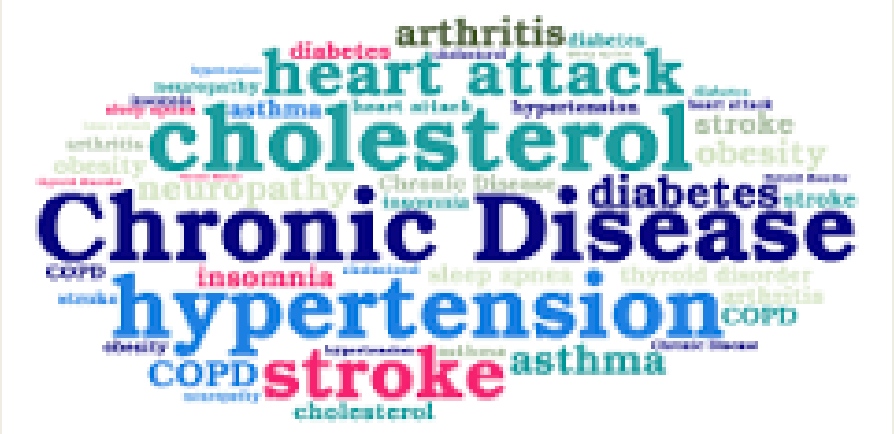
Inpatient and ED visits in three Camden, N.J., hospitals (2005–2007)

	Visits	Patients	Charges	Receipts	Collected
Cooper Hospital	3,172	749	$42,144,097	$4,994,658	12%
Lourdes Hospital	811	337	$7,848,809	$1,028,661	13%
Virtua Hospital	805	331	$1,742,467	$345,092	20%
2005	838	370	$10,834,420	$1,269,373	12%
2006	738	355	$6,867,995	$881,549	13%
2007	790	369	$7,9979,262	$901,181	11%
ED visits	3,882	978	$6,150,592	$864,019	14%
Inpatient visits	906	408	$45,584,781	$5,504,342	12%
Total	4,788	1,070	$51,734,374	$6,368,361	26%

Source: Coopers, Lourdes, and Virtua hospitals and ER billing data from January 2002 through June 2008

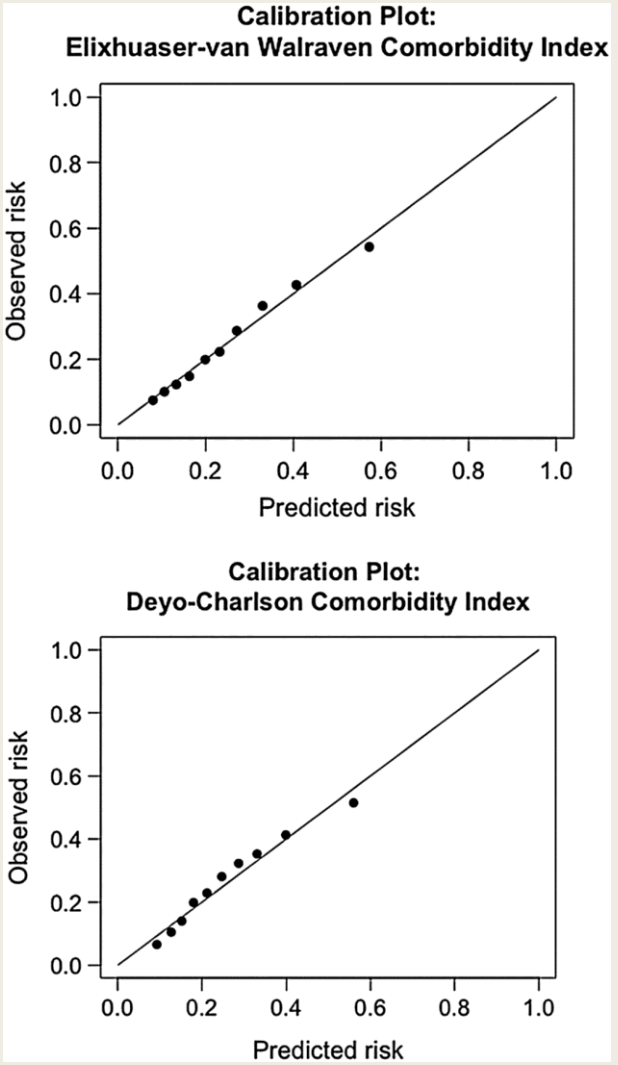
Chronic Condition Counts (CCC)

- CCC method is a comprehensive comorbidity count
- Sum of chronic conditions is grouped into 6 categories
- Has been shown to be associated with high annual patient costs



Comorbidity Indexing

- Originally designed to classify comorbidities affecting 1-year mortality in cancer patients
- It has been shown to predict poor outcomes in large populations



Questionnaires

- Questionnaires and such as the Health Risk Assessment and the HARMS-8 can be used to determine patient risk stratification

- Survey results can be grouped and tiered to determine risk categories

Hybrid Models

- Some organizations go as far as combining multiple models!

So many options, so little time

WHERE DO YOU START?

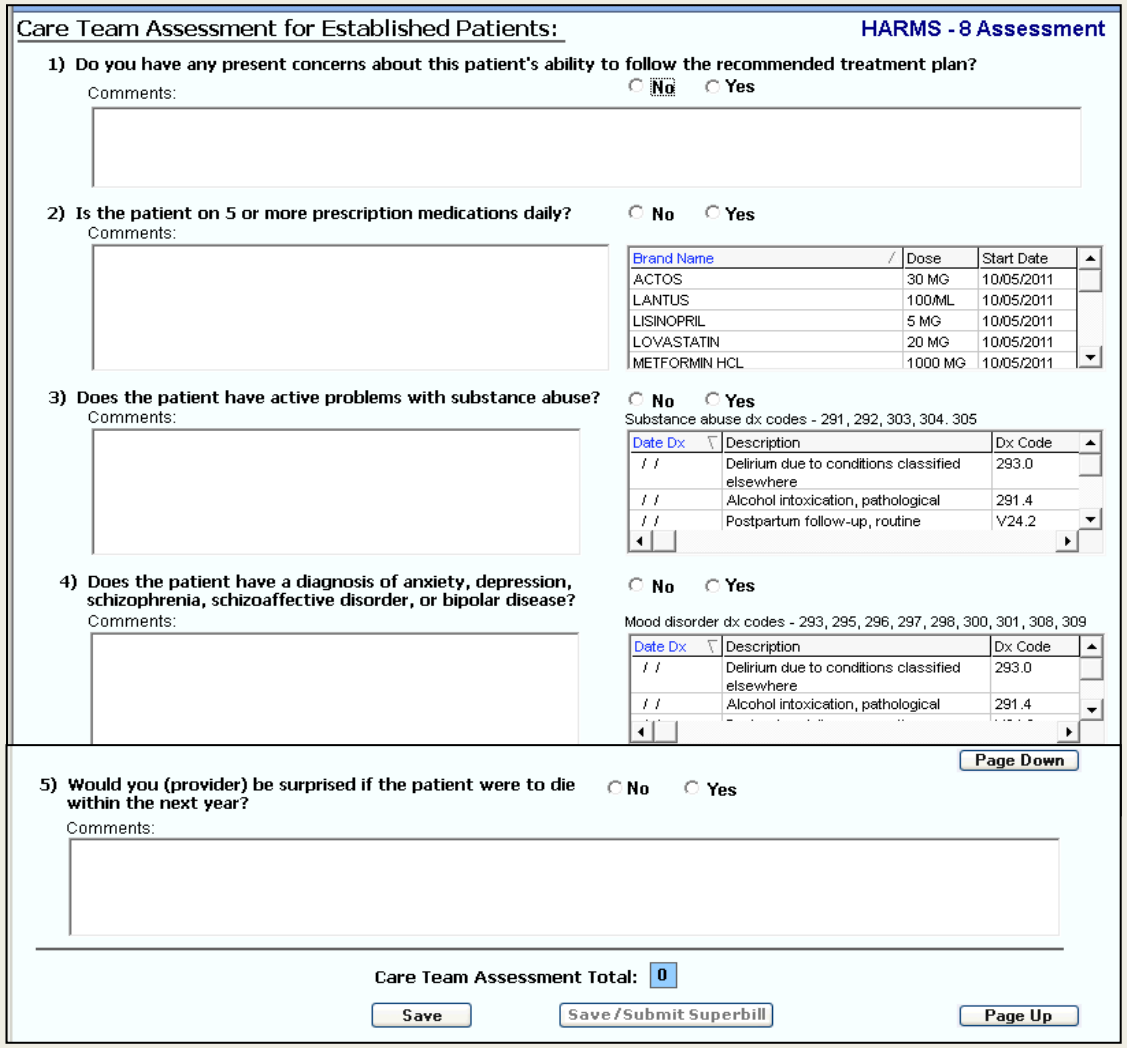
START…ANYWHERE!

- Start with the basics
- Understand your data
  - *EMR*
  - *ACO/RCCO*
- You don’t need anything fancy
- Start with the end in mind
  - *What is your intended outcome?*
    - What resources do you have available?

It’s not always about money

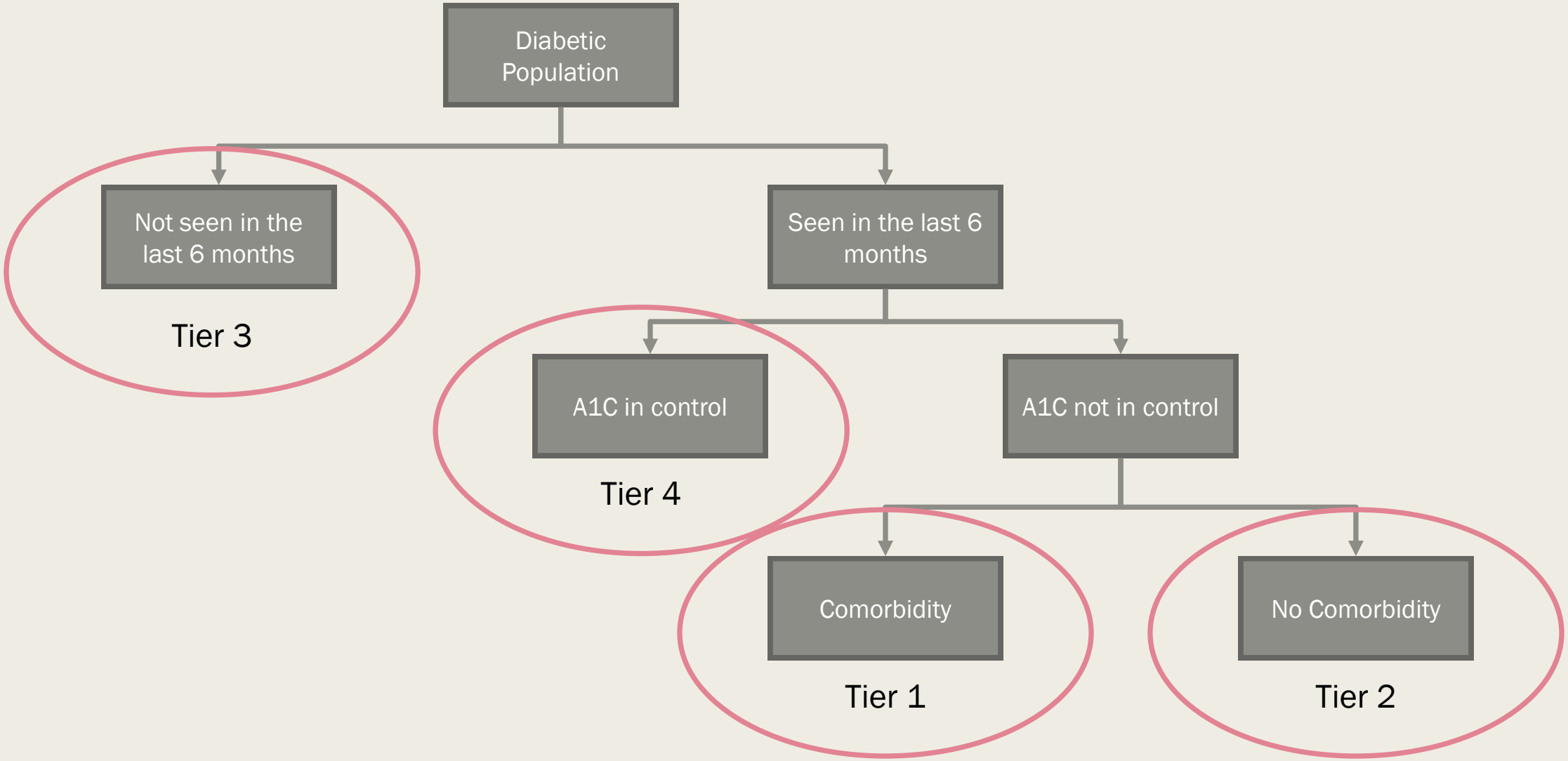
- Down stream stratification models focus on cost and claims
- What happened to just wanting to improve the health of the patient?
  - *This is not reimbursable work*
- Keep your methodology simple
  - *High utilizers*
  - *Specific disease states*
  - *Registry populations*

Simple Questions

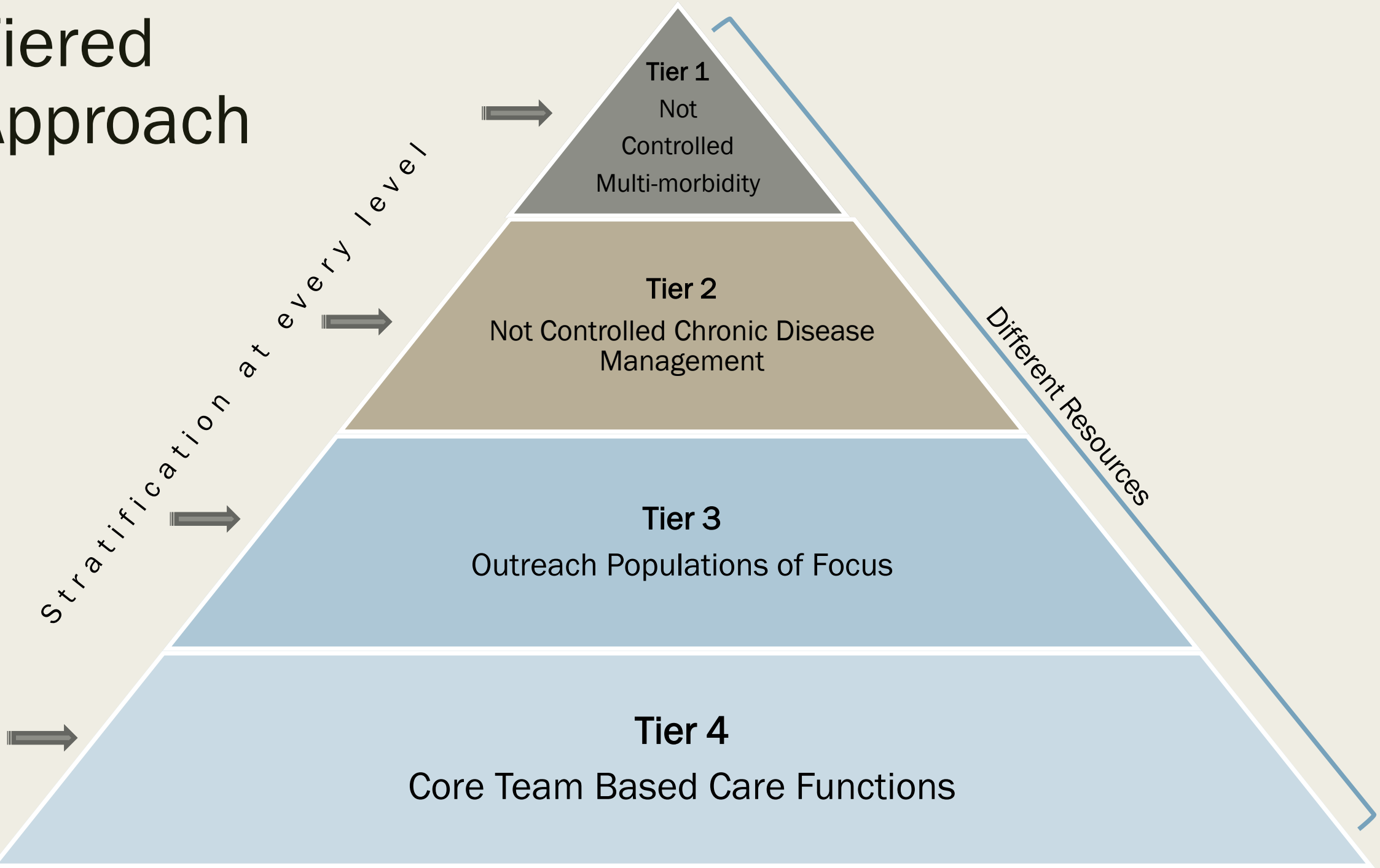


- You already know where to start
- Don’t incorporate too many variables
- Start with your low-hanging fruit
- Start today!

Simple Example



Tiered Approach



Beginner’s luck…or lack there of

- Do not use a stratification model that deviates from your end goal
- Do not get caught up in cost data to predict utilization
  - *It’s not always a 1:1*
  - *High cost, very complex patients may never utilize your clinic*
    - Down-stream stratification models that look at cost and claims do not always predict up-stream clinic utilization
- Do not over stratify - KISS
- Only stratify when you actually have action to take

Questions?

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