OUR TAKE

Refining Your Approach to Risk Stratification

Three steps to identify actionable patients

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Risk stratification is the foundation of scalable population health management. Health care organizations often spend significant time and resources to identify their high- and rising-risk patient populations. However, despite these concerted efforts, many organizations find that those patient groups are still too large to inflect given finite clinical capacity and resources.

The most effective risk stratification takes a more nuanced approach: identifying highly actionable patients, not just high-risk patients.

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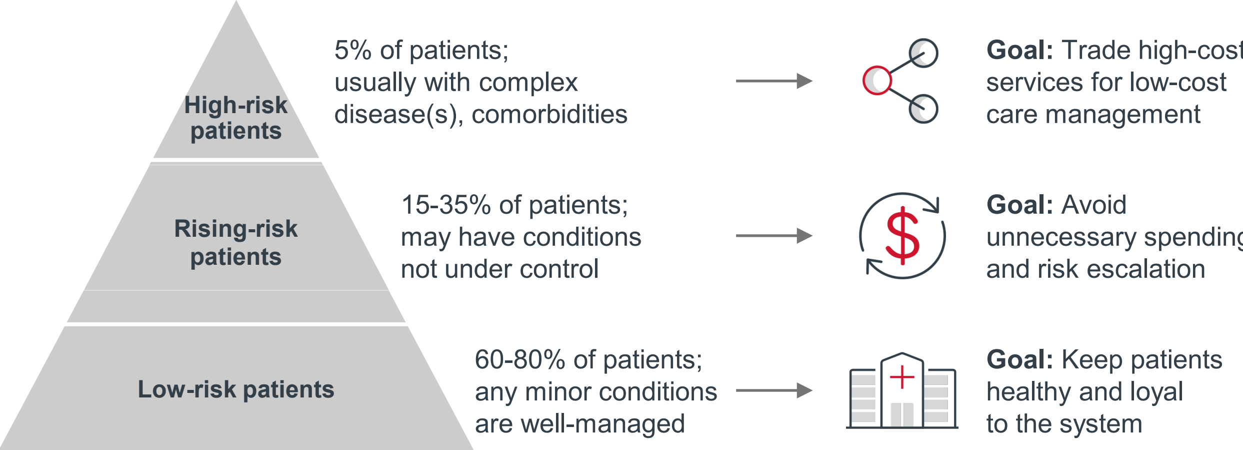
The conventional wisdom

The need to prioritize finite resources and clinical capacity has been growing for years and increased during the Covid-19 crisis. In light of deferred care, organizations have a renewed urgency to identify patients who need increased access and services, such as care management.

To do this, most organizations stratify their patients according to the well-established population health risk pyramid. Organizations, especially those taking on risk, often target high-touch interventions at all high-risk and/or rising-risk patients with the goal of reducing avoidable utilization and the total cost of care.

Population health risk pyramid



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Our take

Offering high-touch support to all at-risk patients often undermines efforts to reduce the total cost of care and spreads organizational resources too thin. Organizations need a more nuanced approach to risk stratification that recognizes some high-risk patients will always remain high-cost.

A more nuanced approach entails concentrating high-touch services on patients who are not just at-risk, but who also have inflectable risk factors. These "actionable" patients make up a subset of the high- and rising-risk categories on the population health pyramid. For example, one study found that just one-third of the 5% most expensive patients demonstrate cost savings through better care coordination and coaching.

When the goal of risk stratification is to identify "highly actionable" patients, not just high-risk patients, organizations can't rely solely on utilization, cost, and disease state to prioritize the right patients for high-touch support. While these metrics are important for risk stratification, they cast too wide a net when used alone—and more importantly don't reflect today's patients, who are often more complex than their clinical condition.

The good news is that organizations don't need to make inordinate IT investments or create the perfect data set to see anticipated cost savings from population health services.

Source: Pear R, et al., "Managing the Most Expensive Patients," Harvard Business Review, https://hbr.org/2020/01/managing-the-most-expensive-patients; Advisory Board interview and analysis.

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Three low-cost steps to identify actionable patients

01

STEP 1

Identify patients with risk factors you can inflect

02

STEP 2

Focus new data collection on metrics that predict future demand

03

STEP 3

Capture actionable patients who are not coming in for care

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01 Identify patients with risk factors you can inflect

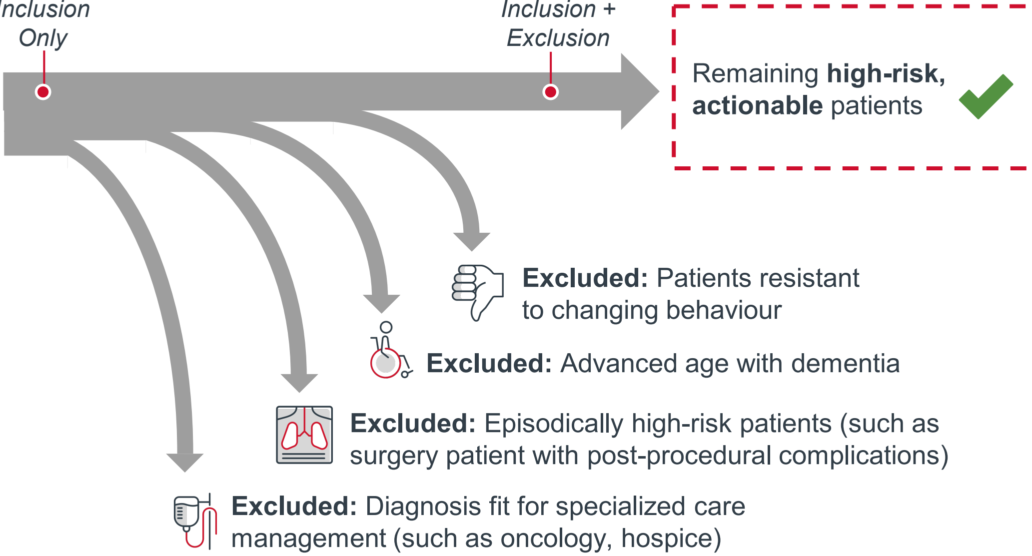
Most organizations already have the data they need to identify their most actionable patients[1]—they just need to leverage it a bit differently. The first step aligns with what most organizations do already: leverage a holistic suite of risk factors, both clinical and non-clinical, to create inclusion criteria.

But inclusion criteria will get you only so far. The likely result is a group of patients that is larger than the average organization can fully support with high-touch services—and many patients for whom costs will be difficult to inflect. Identifying actionable patients requires a second step: overlay exclusion criteria to filter out patients whose high cost or utilization is out of the health system's control. Such patients often require a different care model that necessitates costly, longitudinal support.

Exclusion criteria limits program to those you are fully equipped to help[2]

Large **high-cost** patient pool based on commonly used inclusion criteria:

- Several chronic diseases
- Multiple medications
- High ED visits



1. Example data includes a year's worth of EHR data sorted by CPT codes, number of encounters, number of hospital admissions, and social complexity such as foster care or need for an interpreter.
2. Illustrative example.

Source: "Proactively Identifying the High-Cost Population," Health Care Transformation Task Force, July 1, 2015, https://hcttf.org/wp-content/uploads/2018/01/WhitePaper-ProactivelyIdentifyingtheHighCostPopulation.pdf; Advisory Board interview and analysis.

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Accounting for available resources

Identifying actionable patients cannot be divorced from organizational bandwidth. To truly be “actionable,” the number and type of patients identified must align with an organization’s available services and clinical capacity.

For example, one organization we work with, recognizing their limited number of care managers, used inclusion and exclusion criteria to segment[1] patients by “care coordination burden.” The organization then reallocated RNs to the practices where patients with the greatest care coordination burden were located.

By acknowledging resource constraints early in their risk stratification efforts, organizations can selectively define what constitutes “actionable” and then deploy resources to where they are needed most.

1. Patients were categorized into three groups by disease burden: complex chronic, chronic but stable, and self-managed. Criteria for complex chronic patients included: managed by 2+ specialties, 1+ hospital admission per year, and an added factor for social complexity. Stable chronic patients were those managed by 2 specialties. Self-managed patients were those managed by 1 specialty.

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02 Focus new data collection on metrics that predict future demand

Effective risk stratification requires understanding patients' psychosocial complexity and non-clinical risk factors. While many organizations screen for some non-clinical risk factors, most leaders are unsure what data they should prioritize in order to prevent patient and clinician survey fatigue.

Focus new data collection efforts on information that is easy to identify and predictive of future health care utilization and poor outcomes. Two risk factors deemed high-priority and predictive (especially in light of the dramatic impact of Covid-19) are:

- **Behavioral health:** Uncover behavioral health needs through validated screenings such as, a depression screen, and through conversations about stress-related behaviors, such as smoking or changes in routine.
- **Financial heath:** Uncover through payer status data (particularly dual eligibility) and through nonjudgmental questions about patients' financial worries such as, "Are you able to refill your prescriptions?"

Encourage patients to fill out screens as pre-visit work,[1] upskill MAs or clinicians to sensitively screen, and/or partner with local community organizations[2] to supplement health system data collection.

Focused data collection driven through the EHR or community partnerships can reveal patient demand and need for certain services writ large—and help prioritize population health interventions that can demonstrate return.

1. For all patients, capitalize on routine interactions using validated, electronic self-assessment tools. For high-risk patients, staff can supplement baseline information with psychosocial intelligence gathered from community partners or conduct proactive telephonic outreach and/or in-depth assessments to better understand their needs
2. Consider partnering with public health departments, local care agencies (such as mental health), school districts, faith-based organizations, and other nonprofit groups (like food banks).

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03 Capture actionable patients who are not coming in for care

As organizations work to stratify patients by risk, they will quickly uncover a blind spot: high-risk patients who are disconnected from care altogether. And as patients postpone their care due to continued fear surrounding Covid-19, the number of high-risk, non-utilizers will grow—which will lead to an increased risk of costly health care utilization down the line.

There are two main ways organizations can identify these patients. One way is **geotargeting,** a data-driven method that helps clinicians pinpoint geographic areas of greatest need on which to focus outreach. Such areas can include: areas facing significant job loss, housing instability, high-incidence of Covid-19, and ZIP codes with high levels of high-risk, high-cost patients.

The second, even simpler, way is **mining chronic disease registries** for patients who haven't been seen in a while. Be sure to include factors such as ZIP code and clinician judgment, given that clinicians often know which of their patients are and will become increasingly high-risk. Frontline staff can then proactively reach out to these patients to offer disease support through phone consults, video visits, office visits, remote patient monitoring, or home visits.

These efforts can support organizations' understanding of community drivers of risk—effectively building out their population health enterprise.

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Parting thoughts

Risk stratification strategies will continuously evolve, along with our growing understanding of patient complexity.

How we understand the term "risk" is evolving—from clinical factors, to the addition of social complexity, to patients' behavior and activation levels. Over the coming years, the criteria for what puts a patient at risk will continue to evolve, especially as we expand our thinking on health disparities, racial inequity, and social determinants of health. This continuous shift in how we identify patient risk underscores why risk stratification efforts have and will continue to be a population health challenge. Recognizing this, sustainable risk stratification today requires an iterative approach, developing alongside changing patient needs, organizational priorities, and IT capabilities.

In tandem with this evolving understanding of risk is the growing scope of what organizations can do to intervene in a patient's progression up the risk pyramid. These interventions range from giving clinicians actionable guidance at the point of care to partnering with community organizations to tackle the root causes of what puts a patient at risk. Consequently, today's organizations embracing value based care need to continuously re-evaluate not just patient identification efforts but also patient interventions—recognizing that risk stratification is only as effective as their ability to intervene to improve patient outcomes.

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