

CPC+ Risk Stratification Job Aid

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Purpose

As a part of Comprehensive Primary Care Plus (CPC+), CMS has identified care management as a core function of primary care. In order to do this work effectively, we need to understand the risks and health challenges of the people who come to us for care.

CPC+ requires Track 2 clinics to use a 2-step process to identify patients' risk, including use of an algorithm that stratifies patients based on their risk factors, and a secondary clinical review and adjustment of the risk level assigned by the algorithm. All Providence CPC+ clinics (Track 1 and 2) are encouraged to use this method.

Providence utilizes a risk stratification algorithm that assesses for emergency department and hospital utilization, high-risk medications or polypharmacy, and weighted co-morbidity. This algorithm stratifies our entire patient population into 4 risk tiers. We may then apply a secondary clinical review to adjust a patient's risk level as needed, with the goal of providing longitudinal care management to those patients identified as highest risk.

A report of the algorithm-based risk stratification is generated monthly for all empanelled patients. It is useful as a starting point to adjust risk level based on clinical judgment, for monitoring the number of patients stratified in the various risk levels at your clinic, and to gauge compliance with CPC+ and PCPCH measures. It should be used along with corresponding Epic report functions to assess and manage your high-risk patient population.

CPC+ Risk Stratification Methodology

Data source: Providence Electronic Medical Record data

Overview: This risk stratification methodology systematically risk stratifies our empanelled population into four risk levels. The risk level corresponds to the disease burden and intensity of services the individual may need. Those with the highest needs would most likely benefit from longitudinal care management which is targeted, proactive and relationship-based. People who would benefit from longitudinal care management are risk stratified into the Very Intense risk category.

Exclusions: these people are managed by other programs

- Chronic kidney disease, stage 4 (severe) = N18.4
- Chronic kidney disease, stage 5 = N18.5
- End stage renal disease = N18.6

Clinical judgment: Care Givers will review the risk level assigned by this methodology. Based on their clinical judgment and patient knowledge, patients can be reassigned to different risk levels as appropriate. The risk level can be changed by utilizing the Health Maintenance Module in Epic. The risk level designated by the Care Givers will override the risk level assigned by the methodology.

1. Low Risk: Person is considered low risk if none of the criteria below are met

2. Moderate

People that qualify for category A, B, or C should be considered Risk Level Moderate unless the person qualifies for a higher risk category:

A. Diagnoses (Presence of any of the following conditions based on active problem list):

- | | |
|--|--|
| A. Asthma | I. Hepatitis C |
| B. Back or Neck Pain | J. HIV/AIDS |
| C. COPD/Chronic Bronchitis/Emphysema | K. Inflammatory bowel diseases |
| D. Chronic Ischemic Heart Disease | L. Multiple Sclerosis |
| E. Chronic Kidney Disease (mild to moderate) | M. Neuropathy |
| F. Congestive Heart Failure | N. Rheumatoid Arthritis |
| G. Diabetes | O. Any mental health diagnosis |
| H. Hepatitis B | P. Any obesity diagnosis |
| | Q. Failure to Thrive or Abuse/Neglect Dx |

B. Medications:

- 5+ unique prescribed medications for Adults or 3+ unique prescribed medications for pediatrics **OR**
- Patient has one or more active prescribed medications (excluding OTC meds) from the following list
 - Chronic pain
 - Depression/anxiety
 - Insulin/diabetic meds
 - Inhalers/asthma-COPD
 - Anti-hypertensives
 - Cholesterol
 - Stimulants

C. Active Tobacco User

3. Intense

People that qualify for category A, B, C or D below should be considered Risk Level Intense unless they meet the Very Intense criteria.

A. 2+ Diagnosis-based Conditions Below AND 5+ unique prescribed medications (3+ for Peds)

- | | |
|--|--|
| A. Asthma | I. Hepatitis C |
| B. Back or Neck Pain | J. HIV/AIDS |
| C. COPD/Chronic Bronchitis/Emphysema | K. Inflammatory bowel diseases |
| D. Chronic Ischemic Heart Disease | L. Multiple Sclerosis |
| E. Chronic Kidney Disease (mild to moderate) | M. Neuropathy |
| F. Congestive Heart Failure | N. Rheumatoid Arthritis |
| G. Diabetes | O. Any psych diagnosis |
| H. Hepatitis B | P. Any obesity diagnosis |
| | Q. Failure to Thrive or Abuse/Neglect Dx |

B. 3+ Emergency Department (ED) visits in past 12 months

C. 1+ Hospital stays in past 12 months (excluding normal deliveries based on DRG exclusions)

D. Substance abuse (active)

4. Very Intense

People that qualify for category A, B, C, or D below should be considered Very Intense risk level:

A. 3+ Hospital stays in past 12 months (excluding normal deliveries based on DRG exclusions)

B. 6+ Emergency Department (ED) visits in past 12 months

C. 30-day readmission in the last 3 months. The first admission (the index admission) may be for a normal delivery.

D. 7+ Comorbidity Score and 5+ unique prescribed medication (3+ for Peds)

The Co-morbidity Score formula below is based on 17 separate condition flags (where each flag contributes either 1 or 2 points to the overall score).

$(2 * \text{ASTHMA}) + (2 * \text{COPD/Chronic Bronchitis/Emphysema}) + (2 * \text{Diabetes}) + (2 * \text{Congestive Heart Failure}) + (2 * \text{Chronic Ischemic Heart Disease}) + (2 * \text{Any psych diagnosis}) + (2 * \text{Failure to Thrive or Abuse/Neglect Dx}) + \text{Rheumatoid Arthritis} + \text{Back/Neck Pain} + \text{Neuropathy} + \text{Inflammatory bowel diseases} + \text{Multiple Sclerosis} + \text{Hepatitis B} + \text{Hepatitis C} + \text{HIV/AIDS} + \text{Chronic Kidney Disease (mild to moderate)} + \text{Any Obesity diagnosis}.$

Accessing the Algorithm-Based Risk Report

The algorithm-based risk stratification a spreadsheet report uploaded to Infoview at the beginning of each month. It can be found via the following pathway:


Infoview > Documents > Public folders > PHS Epic > Ambulatory > EpicCare Ambulatory > Medical Home > “CPC Plus Very Intense Patients Month Year”.

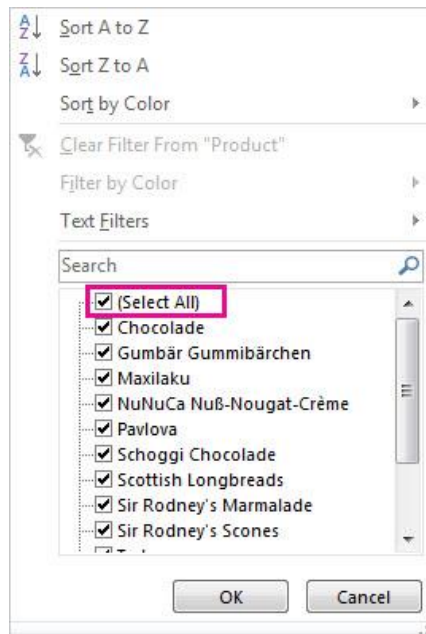
Double-click on the report title to open or save the spreadsheet.

Modifying and Using the Algorithm-Based Risk Report

Filter/Sort Functions

You may choose to filter or sort in a variety of ways depending on how you are utilizing or distributing your list, the staff you have in your clinic, or the roles of those identified to work the report.

1. Click the arrow  in the table header of the column you want to filter.
2. In the list of text or numbers, uncheck the **(Select All)** box at the top of the list, and then check the boxes of the items you want to show in your table. Click **OK**.



Filter by PCP Home – So you only see high-risk patients attributed to your clinic(s). This column can also be hidden after filtering for your clinic is complete - see instructions for hiding/unhiding columns below.

Filter by PCP name – To provide directly to each PCP for their clinical review of stratified risk classification. You may also choose to filter by multiple providers to show a team’s panel of high-risk patients for adjustment of risk classification (if appropriate), monitoring, or recall.

Sort or Filter by New to Very Intense – Patients who are new to the Very Intense risk level since the previous month’s report will show in this column as “Yes”, you can sort or filter for these patients to review their chart and adjust their risk level by entering the appropriate risk level into Epic, and/or begin planning care interventions.

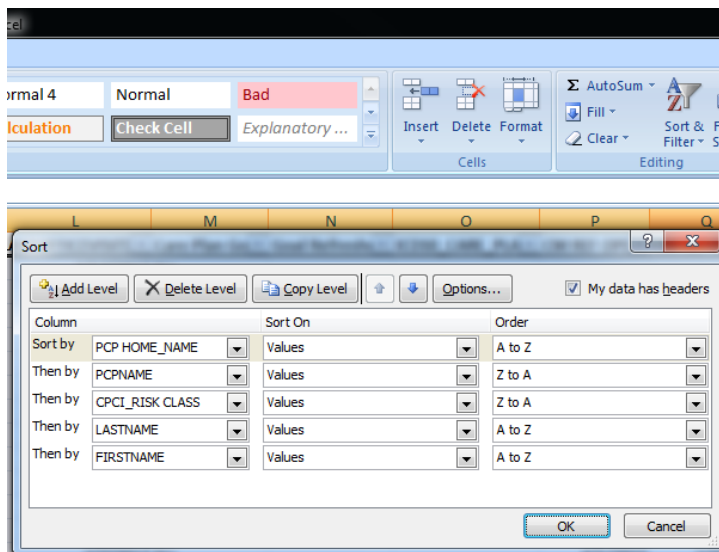
Sort by Next Appointment – To sort by upcoming appointment, to help strategize for in-reach opportunities. Please note that this column shows ANY next appointment scheduled, which may be with specialty, lab, etc.

Sort by Numerator Met/Unmet – May be utilized by a variety of team members to determine and monitor plan of care. *Ex. Sort for all “Numerator Met = No” so team can go through and determine if patient needs an office visit, updated goals, etc in order to meet measure.*

Sort by Care Plan Goal/Goal Refresh Date – Sorted for blanks to identify patients who need goals entered; subsequently could be sorted by date to identify patients whose goals need to be updated or refreshed to continue to meet the measure.

Sort by CM Ref Open/Close – May be utilized by team to identify patients currently/previ-ously working with Case Management, who could advise on risk designation.

Sort multiple columns at once - You can sort by more than one column at a time by selecting all of the data columns, selecting Sort & Filter in your upper right task bar, and selecting Custom Sort.



Adjusting, Hiding, and Unhiding columns

You may wish to adjust the width of the available columns to better fit the information on your screen, or for printing purposes. You may also wish to hide columns you don't want to see, or unhide the risk methodology columns at the end of the report (*Ex. If you wanted to see specifically why a patient triggered the risk algorithm*).

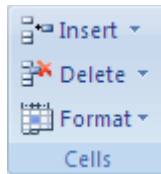
Adjusting column width

1. To change the width of **one** column, drag the boundary on the right side of the column heading until the column is the width that you want.

Drag to resize |

	A	B	↔C
1			
2			
3			

1. To auto-fit **one or more columns** to their contents, select the column or columns that you want to change.
2. On the **Home** tab, in the **Cells** group, click **Format**.



3. Under **Cell Size**, click **AutoFit Column Width**.

Hiding/Unhiding columns

Some columns (R through AU) at the end of the sheet have been hidden – these contain additional data on the listed patients, including how they scored on the risk stratification algorithm. To display these columns, select the columns adjacent to either side of the hidden cells (Q and AV in this case), right click on the selected columns, and click **Unhide** from the dropdown menu. To Hide these columns (or others you don't want to see), select the column(s) you want to hide, right click on the selected area, and click **Hide** from the dropdown menu.

Creating multiple copies/sheets

You may wish to separate this report so each provider or team has their own sheet or tab. To do this without losing the functionality of your spreadsheet, copy the whole sheet into tabs and then continue to sort/filter from there.

1. To copy the sheets, right click on the sheet tab at the bottom of the screen, select **Move or Copy** and check the **Create a copy** check box.
 - a. When you create a copy of the worksheet, the worksheet is duplicated in the workbook, and the sheet name indicates that it is a copy — for example, the first copy that you make of Sheet1 is named Sheet1 (2).
2. To rename the moved or copied worksheet, right-click its sheet tab, click **Rename**, and then type the new name in the sheet tab. (Alternatively, you can double-click the sheet tab and then edit the name.)

156763	8/13/1958	QUERY, CRYSTAL S
156764	2/28/1988	QUERY, CRYSTAL S
156765	3/2/1964	QUERY, CRYSTAL S

Team A **Team B** Team C

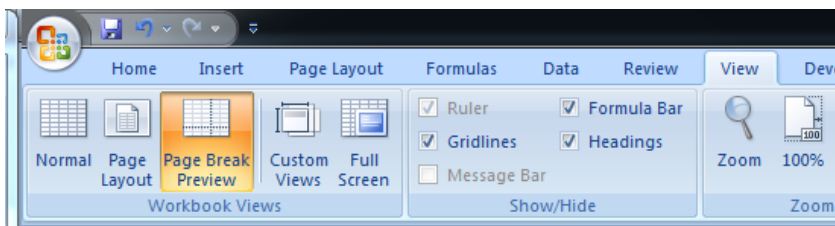
Ready Filter Mode

Printing

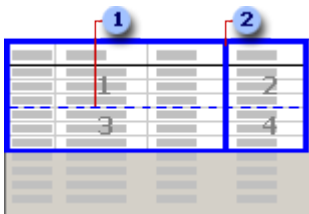
If you'd like to print your list for the team to work or for your records, you'll first need to adjust your page breaks to ensure your data prints in a readable format.

Tip – make sure to reduce your column width and remove any unnecessary columns before adjusting your page breaks, so you have an accurate view of what will fit on your printed page.

1. On the **View** tab, click **Page Break Preview**.



2. Use this view to quickly adjust the vertical and horizontal page breaks.



3. To move a page break, drag the page break to a new location.

Report Definitions

New to Very Intense

Report Definition: This is a comparison to the prior month. If the current month has the patient listed as Very Intense, but the patient wasn't found on the list last month as Very Intense, then this field is "Yes".

Next Appointment

Report Definition: This shows the date of the next scheduled appointment anywhere in the Providence system, including visits with specialty, infusion, physical therapy, etc. It is not specific to an appointment in your department or with the PCP.

** Please note that upcoming visits listed in the report are accurate as of the time the report was run. For real-time information on upcoming visits, use the reporting functions in Epic.*

Numerator Met/Unmet

Report Definition: The numerator can be met in four ways – the patient being open to case management in the last 3 months, having been seen for an office visit (of any kind in the PCP clinic) in the last 3 months, having an active patient goal, or having an active "Care Plan" problem on the problem list. The "Care Plan" on the problem list is an older tracking method, and will be phased out as we transition over to capturing patient goals.

HM Risk Class

Report Definition: This populates with the risk level currently showing in Epic under Health Maintenance. Adjusting the risk level in Epic will override the algorithm and subsequently change the level listed in this column. Patients without a risk level pushed to Epic (initial push occurred on 4/21/17) will need their risk level entered manually into Epic, and will show as NA until this is done.

Last Office Visit

Report Definition: Arrived/Completed office visit in last 3 months at the PCP clinic (Office Visit, Historical Visit Scan, and Outpatient Historical encounter types). Includes visits with PCPs, PA-Cs, NPs, BHI, RN and PharmD.

** Please note that last visit dates listed in the report are accurate as of the time the report was run. For real-time information on completed visits, use the reporting functions in Epic.*

Care Plan Goal & Goal Refreshed

Report Definition(s): The patient has a goal listed in Epic (see link to LPOC - Longitudinal Plan of Care – in the resources section for more information on patient goals). Goal refreshed shows the most recent date one or more of the goals listed was refreshed.

ICD10 Care Plan

Report Definition: Shows patients who have an ICD10 code of Z00.8 Care Plan on their problem list that has been refreshed in the last 3 months. This was the old method of tracking care planning efforts for high-risk patients, and will be phased out as we move toward using patient goals for this.

Condition Columns

Report Definition: Pulled from ICD9/ICD10 codes of active problems on a patient's problem list for the associated conditions in each column.

ED Visits

Report Definition: ED Visits listed in the report reflect only visits occurring within the Providence system at this time, which may not accurately reflect overall ED utilization for those patients who are frequently seen outside our system.

Hospital Visits

Report Definition: Hospital Visits listed in the report reflect only visits occurring within the Providence system at this time, which may not accurately reflect overall hospital utilization for those patients who are frequently seen outside our system.

EPIC Reporting

See the Epic Reporting presentation for steps to set up and use Epic to audit for real-time data on your high-risk patients.

(Placeholder for additional report info)

DRAFT

Additional Resources

[CPC+ SharePoint](#)

Please refer to the CPC+ SharePoint site for additional support documents and best practices.

[Longitudinal Plan of Care \(LPOC\)](#)

Please refer to LPOC support documents on the CPC+ SharePoint (under Best Practices > Care Management) for details and workflows around entering and modifying patients goals in Epic.

Contacts

You may also contact a CPC+ Program manager if you have additional questions:

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