Using Risk Score Tools To Identify Populations for Intervention and Pilot Population Intervention

Primary Drivers
(Systems, Structures, Norms)

Secondary Drivers
(Change Concepts)

Change Ideas

Aim Statement

By June 30th, 2025, health centers will utilize a standardized risk score tool to identify a population and create distinct objectives from the previous years' measure

Access

Panel Management
Panel Weighting
Utilization

- High risk score and panel weighting-a person with risk score of 5 counts as 1.2 and pilot provider panel.
- Report- identify patients with high-risk score and low utilization versus patients with low-risk score and high volume of visits and pilot workflow for CM, outreach for f/u, PRAPARE screening etc.
- Identify patients with a high-risk score and SDOH and pilot workflow for CM, outreach for f/u, closed-loop referral
- Look at those with high-risk score and behavioral health diagnosis and pilot workflow/ schedule template CM, outreach for f/u, PRAPARE screening
- High risk score and open referrals and pilot workflow/ schedule template CM, outreach for f/u, PRAPARE screening
- Utilization – stratify the number of "touches" needed per timeframe (e.g. weekly, monthly, quarterly) and pilot or test workflow

Care Team Decision Making

Patient Engagement

- Stratification of population to identify patients for case management and pilot CM workflow
- Report to evaluate patient adherence to prescription drugs that also have high risk scores and utilize list to conduct patient outreach by pharmacy
- Using risk score plus engagement level and incentivizing engagement (e.g. gift cards, provider kudos, etc., to incentivize engagement with RPM) and pilot incentive program

Staffing

Increasing care team capacity

- Identify care teams with high risk and identify staffing up or re-staffing teams (examples: using risk score during huddle to plan staffing for each visit (MA, Nurse, Navigator, etc.) and pilot a workflow using this approach