	# 703	High-Risk Registry X Policy ☐ Standard Operating Procedure					
Date of Inception:		5/31/2018	**CEO Approval:**				
Current Approval Date:		08-07-2023	**CMO Approval (If Required):**				
Operational Scope:	Board Directors ☐	Admin ☐	PF ☐	CC / QM ☐	Rights ☐	RCM ☐	ERS ☐
H/S ☐	IHS ☐	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☒

703 Policy:
To establish standards, criteria and methods for identifying and prioritizing service participants with the greatest risk through use of a High-Risk Registry and selection process.

703.1 Scope
All Provider Health employees.

703.3 Procedure

I. Structure

A. Provider Health (Provider) has established a High-Risk Registry based on factors identified in the literature (High-Risk-Patient Identification: Strategies for Success. Association of American Medical Colleges and National Association of Accountable Care Organizations, 2016).

B. The High-Risk Registry includes members at risk for a behavioral or physical health condition who are also at high-risk of:
   a. High unnecessary utilization of hospitals and emergency rooms without remediation of the issues causing the admissions.
   b. Experiencing a decline in physical and/or behavioral health status.

The High-Risk Registry utilizes data and reports obtained from multiple sources to prioritize members for more intensive care including Care Coordination and/or Care Management. Data sources used to help assess members' high-risk status include ED and IP admit and discharge alerts from Contexture HIE as well as information from the member's electronic health record including Court Ordered Treatment and amendment history, active and historical medication prescriptions, Social Determinants of Health (SDOH) assessments, and history of the member's previous or current tenure at higher levels of care.

The electronic registry of high-risk members is kept via an internally developed webapp that is accessible to appropriate staff, with information regarding the clinic the member is associated with, what date they were placed on the registry, comment information from staff, and ability to sort based on custom criteria. 4.1 C

Recommendations are based on a weekly refresh of data that is provided to the clinical staff (ICCs/ICMs) via an automated dashboard. The recommendations can include adding new members to the registry, maintaining current members, or graduating members from the registry, and provides a summary of factors contributing to the recommendations. Clinicians review the recommendations as part of ongoing regular discussions of the high-risk registry members focused on identifying or implementing appropriate interventions or assessing the member's future status on the registry. 4.1 D

C. Specific data sources include, but are not limited to:
   a. Information provided by managed care organizations (MCOs)
   b. The Provider electronic health record (EHR)
   c. Information provided by hospital emergency rooms and inpatient settings
   d. Health Current (HIE) Admission-Discharge-Transfer (ADT) alerts
   e. Other Population Health Measures such as Appointment No-Shows, Readmission, Health equity assessments based on the SDOH assessment.
   f. Individuals identified by the Provider Care Teams who are experiencing a decline in their physical and/or behavioral health status and are emerging risk candidates. 4.1 B
   g. Pharmacy data sources.

CI. Individuals who are responding to the designed interventions may be moved to the Medium Risk Registry if they demonstrate a substantial interval where the targeted interventions have produced positive outcomes.

CII. Members identified and placed on the High-Risk Registry are those whose status may be improved or favorably affected through practice-level care management offered by Provider and/or a coordinated health plan care management program.

II. Risk Stratification and Selection

A. The Provider Director of Population Health and Population Health staff identify potential candidates for the High-Risk Registry using the multiple data sources noted in Section I.C and from data from other population health tools.

B. Provider will maintain a detailed protocol for determining the primary factors that result in a member identified as high-risk. These criteria are based on population health data reviewed in the QM Committee.

C. Provider determines high-risk based on a combination of multiple factors that include, but are not limited to:
   a. Participants who have been determined to have a Serious Mental Illness and are enrolled as a TXIX recipient at a Provider facility.
   b. Participants with a psychiatric diagnosis of Schizophrenia, Schizoaffective Disorder, Bipolar Disorder and at least 1 chronic medical condition.
   c. Individuals identified by their Clinical Care teams as experiencing a decline in their physical, behavioral or social status.
   d. Individuals with high utilization of Emergency Rooms and Inpatient Hospitals. 4.1 A

III. Emerging Risk

Copa also uses the following criteria to determine members who have potential to be at high-risk who have near-term increases in behavioral or physical health service utilization or are

experiencing a decline in their physical and / or behavioral health status. Example include the following:

A. Member's visit pattern to the ED or Hospital has increased and:
    a. Member had a recent inpatient admission due to a suicide attempt or overdose;
    b. Member has utilized the ED the five (5) or more times or hospitals more than two (2) times in the past year.

B. Members who have multiple incarcerations.

C. The Clinical Care Team assesses the individual data and determines whether the person is placed on the High-Risk Registry or whether other interventions are more appropriate.

IV. Candidate Selection and Assignment

A. All members determined to be at high-risk will be reviewed by the Population Health Department including the Care Manager to determine if frequent hospital utilization or ED utilization is due to:
    a. Terminal Illnesses;
    b. A chronic condition that requires these levels of care; or
    c. Acute conditions with short term intensive services
    d. Other conditions where possible clinical interventions have low probability of affecting the outcome.

B. Members determined not appropriate for the High-Risk Registry are referred to the Care Team for targeted follow-up and support.

C. For members who are assigned to the High-Risk Registry, the Care Manager, Integrated Care Coordinator and the staff on the Clinical Team develop:
    a. A complete comprehensive Integrated Service Plan based on the findings of a Comprehensive Assessment and Functional Risk Analysis. 4.1 E
    b. Specific targeted interventions.
    c. Assigned staff implement the Service Plan with monthly progress reviews.
    d. Plans are adjusted as necessary to ensure that the participant receives the services and supports, they need to be successful and healthy.

V. Appointment Prioritization

A. The Integrated Care Coordinator and Care Manager monitor individuals who are on the High-risk and Emerging Registries using the HIE and other data sources. Data is presented to the Care Team at the daily Huddle and Integrated Morning Meeting. The Integrated Care Team determines if adjustments in services are required and the urgency of appointments or revisions to the Individual Service Plan.

B. Based on the presenting bio-psycho-social condition, including emerging acute needs, the Facility Clinical Director and/or the Program Director prioritize appointments for psychiatric, medical, case management, housing, peer supports and other resources. (See Attachment 1: Prioritization of Appointments Workflow).

C. While individuals will maintain their appointment schedules for routine needs, appointments for any emerging urgent need are prioritized for scheduling. The Clinical Director and Program Director are responsible for scheduling.

D. The prioritization of High-Risk appointments is added as data elements to the routine Quality management Case File Reviews. Reports are distributed to the Facility Leadership on an ongoing basis.