Responses to
Risk Stratification

A discussion paper for NSW Health’s Approach to Risk Stratification
In December 2014, the Agency for Clinical Innovation released a discussion paper: Risk Stratification: A discussion paper for NSW Health’s approach to Risk Stratification, seeking feedback and comment from interested parties.

Thirty responses were received and analysed, and the information is being used to inform the next steps in the Risk Stratification Program. The key themes and issues raised in the responses are summarised in this report.

**Approach**

Overall, responses considered that the discussion paper was comprehensive and addressed the key elements of patient risk stratification. There was support for a shift of focus from just high and very high risk patients to include medium risk and others where prevention has a role. There was a positive response to the establishment of a state wide approach that incorporates primary care, community care, and hospital based care.

There was generally good alignment between the approach outlined in the discussion paper, and current activities within Local Health Networks, and their anticipated future direction. However, one response noted the need to better understand and learn from existing activities within NSW, incorporating a bottom-up and top-down approach. In addition, there was a reflection that further and broader consultation early in the program would build engagement and support for the implementation phase.

There was agreement that the paper identifies the strengths and limitations of international approaches and that application of existing models from other jurisdictions would require considerable customisation for application in NSW.

The context is important for both defining the risk that we are trying to reduce, and for having some sense of the interventions (and resources) that may be used. This also feeds into consideration of cost-effectiveness and opportunity cost of tool development and implementation.

Feedback acknowledged the need for a phased and iterative approach that incorporates learnings and additional data as they become available. It will be important to ensure that the approach can broadly guide patient selection activities across a range of population cohorts, levels of risk, desired outcomes, interventions and settings. It was also noted that in addition to identifying individuals or cohorts, risk stratification can provide information to support the design of health and social care services with capacity to match the needs of the local population.

Inconsistent terminology and definitions were highlighted in a few responses, and ACI agrees that it will be important to build a consistent understanding of key terms across the system. A glossary of key terms will developed over the coming months.

**Factors or variables**

A range of possible factors or variables, and the possible methodologies for identifying the strongest predictive factors, were discussed in the responses.
In particular, responses noted the important role of social factors as determinants of health, and the challenges with a lack of this data within current datasets. One Local Health District welcomed any inclusion of a social disadvantage measure as mandatory field item in data collection systems. However, another response expressed some concern about the use of a ‘whole of system’ approach and whether this would take account of the impact of social factors at an individual person level.

Previous utilisation of health services was commonly considered to be a likely predictor of future utilisation. It was noted that people who identify as being an Aboriginal and/or Torres Strait Islander person may be more likely to experience poorer health outcomes, and people with Cultural and Linguistically Diverse (CALD) backgrounds may also be at increased risk. Other possible predictive factors raised included disease specific clinical measures, whether the person’s General Practitioner is fluent in that person’s primary language, mental illness, drug and alcohol misuse, rurality/remoteness, frailty, cognitive function, health literacy, polypharmacy and use of blister packs, disability, lifestyle risk factors, family history, isolation (e.g. living alone), social deprivation and residential address/postcode.

It was noted that some strong predictive factors, based on published evidence, may not currently be recorded for NSW residents or that data may not currently be available for use by NSW Health and partners.

It was proposed that if NSW Health identified a set of variables from the Admitted Patient Data Collection that may improve our ability to predict a group of people at higher risk of admission in the next year, and that this would be a useful initial outcome.

DATA

It is anticipated that access to data variables and datasets will evolve over time. Information was provided about a number of projects or studies underway to extract data from primary care systems and link with hospital data at an individual patient level, including MedicineInsight, the ePBRN established in South West Sydney, the BEACH study and the DaPPHne study.

The importance and interdependencies with data linkage and eHealth architecture were highlighted in a number of responses. The Patient Flow Portal (PFP)/electronic Medical Record (eMR) Integration Steering Committee is currently involved in a project to access data from the eMR for use in the PFP (specifically the Electronic Patient Journey Board module).

Responses included a range of views on the possible inclusion of additional (mandatory) data fields, and the likely completion rate, training needs etc., compared with the added value of having that information recorded. Validity of each data variable is also important, including collection methodology, e.g. whether the question asked is likely to elicit the information sought from the person.

Data governance was raised in a number of responses, including the breadth of this topic. Data governance is not only control of access and use, but also data quality management across the whole enterprise including data, knowledge and system integration. It was considered that optimal data governance would encourage engagement with the primary care sector. The electronic Practice Based Research Network (ePBRN) data depository
developed in South Western Sydney has been examining some of these issues with its partners in Australia as well as internationally.

Further guidance was requested for data governance, particularly the regulations and tools for sharing patient-level information.

**IMPLEMENTATION: OPPORTUNITIES & CHALLENGES**

Many responses considered that this was an important program of work but noted a range of challenges in implementing risk stratification processes.

Further guidance was requested for ethical, patient consent and information governance issues.

Although, social factors are potential predictors of future health care need, addressing these social determinants for individuals will require cross-sector collaboration with other government sectors (Housing, Education, Welfare, etc.) and the non-government and community sectors.

It will be important to avoid duplication and link systems where possible to support efficient working across specialties or settings. ACI will work with eHealth in the design, prioritisation and implementation of technology and architecture to support risk stratification.

A number of comments were provided regarding the intervention(s) or care pathway(s) for patients after they are selected through the risk stratification process. In particular, responses highlighted the need for ‘Whole of Health’ strategies to improve patient care pathways.

Feedback was provided on possible interventions to better integrate care for patients, and these comments will be fed into the relevant parts of the Integrated Care Program.

**ERRORS**

A small number of responses highlighted factual errors in the Discussion Paper. ACI is grateful for this advice and will correct these sections in future guidance publications.

**CONTACT**

For further information regarding the Risk Stratification Program please contact:

Erin Lilley, Integrated Care Projects Manager
Ph: 02 9464 4648  |  Email: erin.lilley@health.nsw.gov.au