



Trinity Health

# PRISM Framework

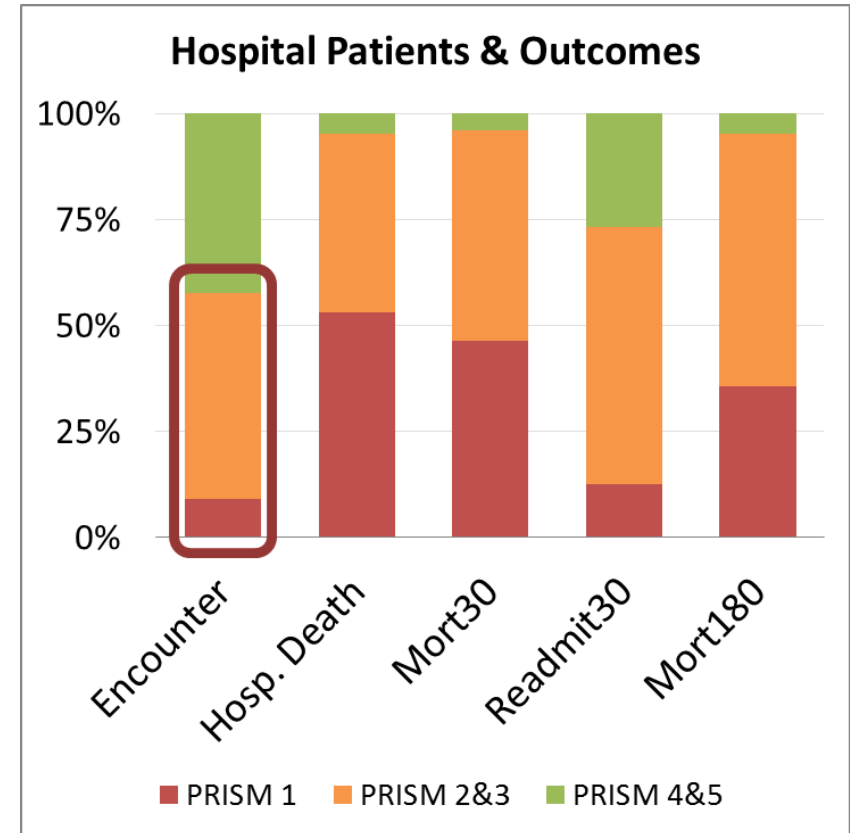
Connecting Michigan

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# PRISM Story: Making Patient Risk Visible, Actionable

- Identify subset of patients with most of the adverse events
- Create one simplified, common language across disciplines & settings
- Align resources, processes to patient needs
- Implement defined, coordinated & anticipatory interventions by risk (bundle)



# PRISM as a Risk Prediction Tool

- Developed in 2012 by Center for Healthcare Analytics and Performance Improvement, Saint Joseph Mercy Health System

- **Probability of 30-day mortality is generated and grouped into 5 strata:**

**PRISM 1            →            PRISM 5**  
**Highest Risk    →            Lowest Risk**

AROC	
30-day mortality	(0.88)
180-day mortality	(0.89)
Palliative status	(0.89)
Unplanned Transfer	(0.74)
30-day readmission	(0.69)

- Scores are generated prior to admission for adult, non-obstetrical inpatient admissions (Medical and Surgical)

Cowen ME, Strawderman RL, Czerwinski JL, Smith MJ, Halasyamani LK. Mortality predictions on admission as a context for organizing care activities. J Hosp Med, 2013;8:229–235.

# PRISM Risk Score Components

## Provided by Clinician

### Current or past history of:

- Cognitive Defect
- Other Neurological
- Atrial Fibrillation
- Cancer
- Metastatic Cancer
- Leukemia

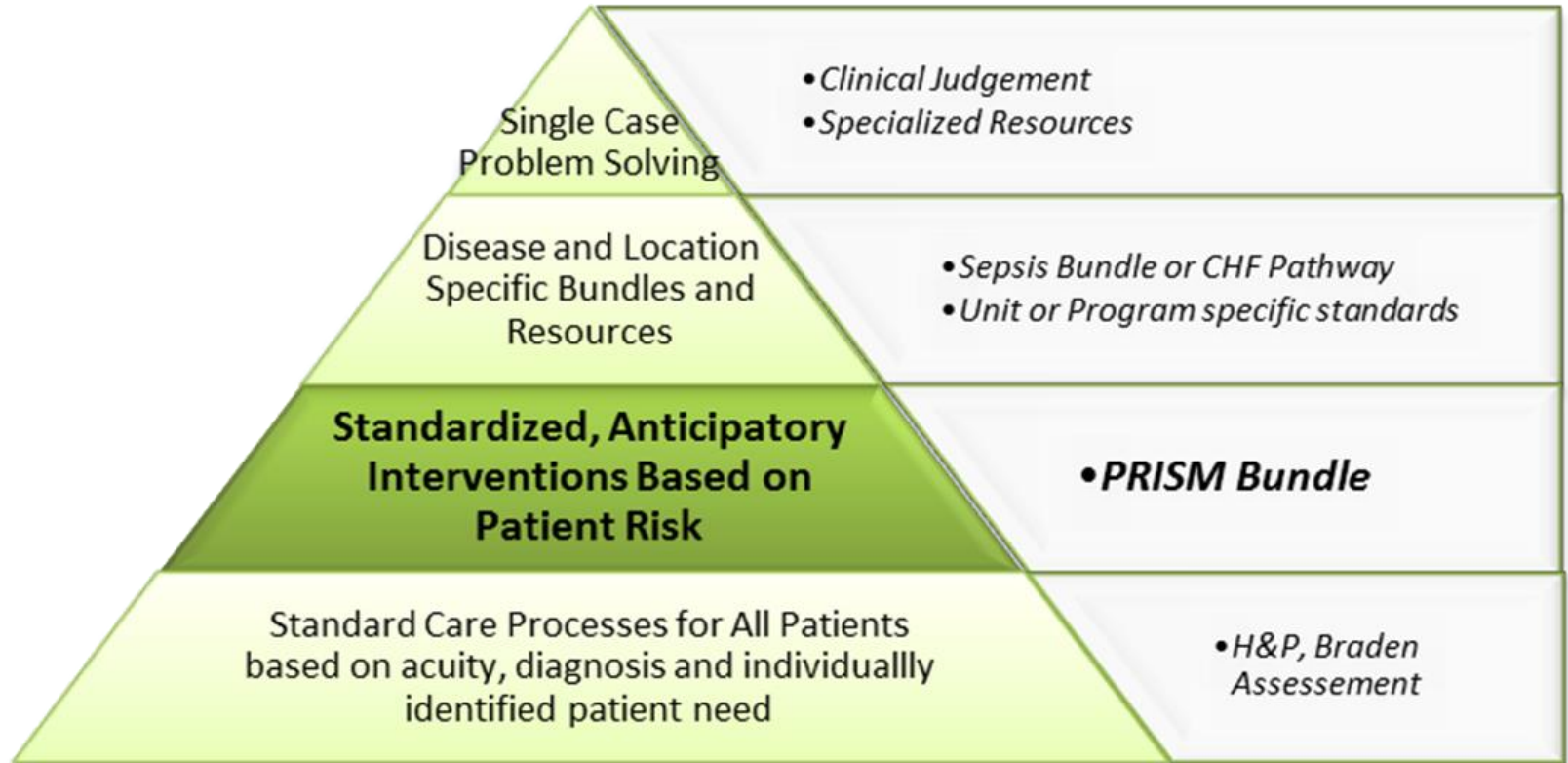
### Currently have:

- Respiratory failure
- Injury
- Heart Failure
- Sepsis
- Medical v/s Surgical Admission

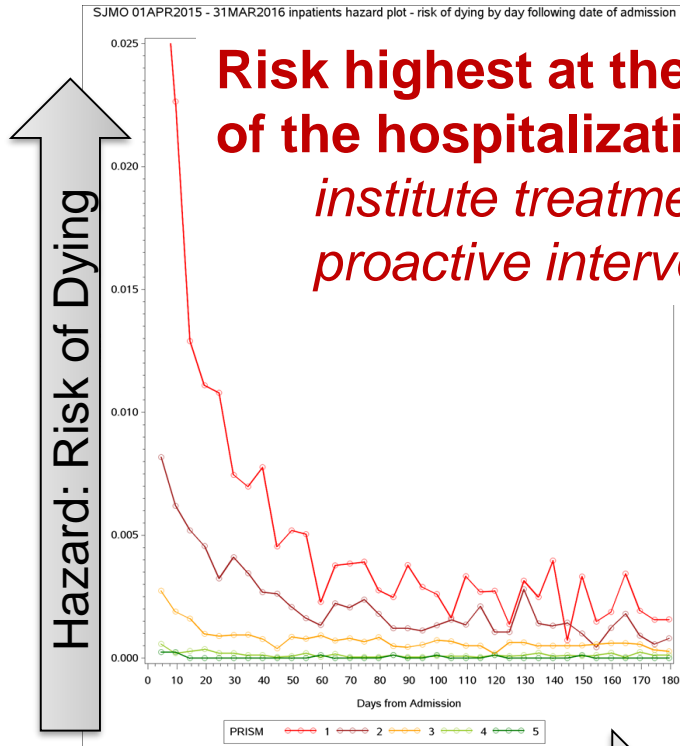
## Obtained Electronically

- Age
- Gender
- BUN
- WBC
- Platelet Count
- Lactate
- Hemoglobin
- Albumin
- Arterial pH
- Arterial pO<sub>2</sub>
- Troponin
- Hospitalization (prev. yr)
- Emergent Admission

# PRISM as a Patient Care Framework



# PRISM Bundle: Align Resources to Patient Risk



**Risk highest at the beginning  
of the hospitalization:**

*institute treatment quickly,  
proactive interventions*

**Heightened risk persists:**

*support for transitions, care  
management beyond hospitalization*

**Admit to 180 days**

# PRISM Bundle Interventions: Examples for Highest Risk Patients

## **During hospitalization**

- Early Assessment and Plan of Care initiated
- Case Management
- Targeted Pharmacy Counseling
- Nutrition Consult and healthy snacks
- Palliative Care Consult

## **After hospital discharge**

- Coordinate post-discharge interventions (like phone calls)
- Home Care and SNF specific bundles
- Offices using PRISM for prioritizing follow up processes, assigning complex care coordination, etc

# PRISM Framework for Population Health Mgmt:

- Capture prospective scores at key points of contact
- Communicate right information at the right time to the right members of the care team
- Stratify population with PRISM, align care processes & resources
- Layer on more specific risk information (by disease, event, specialized intervention, etc) only where it adds value