Risk-Stratified Care Management and Coordination

AAFP

Table 1: Example of Risk Factors to Consider When Assigning Risk Levels

Clinical Diagnoses, Behavioral Health Considerations, Special Needs	Potential Physical Limitations	Social Determinants	Utilization	Clinician Input (Personal Knowledge)
• Advanced age with frailty • Behavioral/mental health diagnosis • Chronic disease, particularly those not at desired goal • Chronic pain • Dementia/Alzheimer's Disease • Dental health needs • Multiple co-morbidities • Pre-term delivery of newborn • Patients with special needs • Terminal illness • Substance abuse	• At risk for falls • Declining eyesight • Extreme weakness or fatigue • Hearing loss • Needs assistance with Activities of Daily Living (ADLs) • Non-ambulatory • Severely diminished functional status	• Lack of family support that impacts care • Lack of financial support • Lack of sufficient financial resources • Lack of transportation • Language barriers • Lives alone • Low health literacy • Medicaid/Medicare dual eligible • Unemployed • Uninsured/underinsured • Unsafe home environment • Unstable housing	• Dialysis • Expensive medications • Frequent ER or urgent care visits • Frequent hospitalizations • Hospital readmission within 30 days • Major procedure in last year • Multiple clinicians	• Answer the question: Is this patient likely to be hospitalized in the next 30 days, six months, year? • Difficulty following treatment plan • Difficulty taking medications as prescribed • High-risk medications • Low confidence or ability for self-management • Polypharmacy • Recent visit to a long-term facility or other transition of care • Spouse/partner recently deceased

Table 2: Identifying Disease Burden, Determining Health Risk Status, and General Care Plan Considerations

Is the patient healthy, with no *significant risk factors?*	Is the patient healthy, but at risk for a chronic disease, or has other *significant risk factors?*	Does the patient have one or more chronic diseases, with *significant risk factors,* but is stable or at desired treatment goals?	Does the patient have one or more chronic diseases, with *significant risk factors,* and is unstable or not at treatment goal(s)?	Does the patient have multiple chronic diseases, *significant risk factors,* complications, and/or complex treatment(s)?	Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?
Level 1 **PRIMARY PREVENTION**	**Level 2** **PRIMARY PREVENTION**	**Level 3** **SECONDARY PREVENTION**	**Level 4** **SECONDARY PREVENTION**	**Level 5** **TERTIARY PREVENTION**	**Level 6** **CATASTROPHIC CARE**
GOAL: Prevent onset of disease (Low Resource Use)	**GOAL:** Prevent onset of disease (Low Resource Use)	**GOAL:** Treat a disease, reduce rising risk, and avoid serious complications (Moderate Resource Use)	**GOAL:** Treat a disease, reduce rising risk, and avoid serious complications (Moderate Resource Use)	**GOAL:** Treat the late or final stages of a disease and minimize disability (High Resource Use)	**GOAL:** May range from restoring health to only providing comfort care (Extremely High Resource Use)
CARE PLAN SUGGESTIONS • Preventive screenings and immunizations • Patient education and engagement • Health and social risk assessment (annual) • Appropriate monitoring for warning signs	**CARE PLAN SUGGESTIONS** • Preventive screenings and immunizations • Patient education and engagement • Health and social risk assessment (annual) • Appropriate monitoring for warning signs • Interventions for unhealthy lifestyle/habits • Links to community resources to enhance patient education, self-management skills, or special facilities	**CARE PLAN SUGGESTIONS** • Preventive screenings and immunizations • Patient education and engagement • Health and social risk assessment (semi-annual) • Appropriate monitoring for warning signs • Interventions for unhealthy lifestyle/habits • Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** • Group visits • Home self-monitoring • Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings	**CARE PLAN SUGGESTIONS** • Preventive screenings and immunizations • Patient education and engagement • Health and social risk assessment (semi-annual) • Appropriate monitoring for warning signs • Interventions for unhealthy lifestyle/habits • Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** • Group visits • Home self-monitoring • Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings • Health coach • Referrals, as appropriate	**CARE PLAN SUGGESTIONS** • Preventive screenings and immunizations • Patient education and engagement • Health and social risk assessment (quarterly) • Appropriate monitoring for warning signs • Interventions for unhealthy lifestyle/habits • Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** • Group visits • Home self-monitoring • Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings • Health coach/personalized care plan/management and resources • Referrals, as appropriate • Home health	**CARE PLAN SUGGESTIONS** • Hospitalization • Rehabilitation • Long-term care • Hospice/palliative care **TEAM/PLANNED CARE** • Support groups • Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings • Health coach/care management • Referrals, as appropriate • Home health • Personalized intensive care plan/management and resources

Table 3: Risk Categories and Levels Using Diabetes Example Case

CATEGORY	PRIMARY PREVENTION (Low Resource Use) GOAL: Prevent onset of disease		SECONDARY PREVENTION (Moderate Resource Use) GOAL: Treat a disease, reduce rising risk, and avoid serious complications		TERTIARY (High Resource Use) GOAL: Treat the late or final stages of a disease and minimize disability	CATASTROPHIC/COMPLEX (Extremely High Resource Use) GOAL: May range from restoring health to only providing comfort care
Stage	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**Level 6**
General descriptions of risk levels	No known diagnoses or complex treatments	No known diagnoses but demonstrates warning signs or potentially significant risk factors	Has diagnosis, but stabilized or in control; potentially significant risk factors	Has diagnosis and/or complex treatment, and at higher risk for complications or potentially significant risk factors	Has diagnosis, complex treatment, and complications or potentially significant risk factors– goal is to prevent further complications	• Very severe illness or condition and potentially significant risk factors • End-of-life care (May have high costs with limited or no opportunity for improvement, stabilization, or cost control)
Example using progression of diabetes	• Healthy	• Blood glucose and lipids rising, but still within desired parameters • BMI elevated • Smoker	• Diagnosed with type 2 diabetes; blood glucose, lipids brought within desired parameters • Married, family involved	• Blood glucose and lipids not within desired parameters • Cannot afford to refill insulin this month • Recently developed Microalbuminuria • Depression • Lives alone • One ER visit and one hospitalization in past year	• Has diabetes with early renal disease, coronary artery disease, failing eyesight, and lives alone • Developed a foot ulcer • Multiple medications • Three ER visits and two hospitalizations in past year • Dual eligible Medicaid/Medicare • Needs assistance with ADL	• Diagnosed with lung cancer • Recent myocardial infarction • Progression to ESRD with renal dialysis • Amputation of one leg • Blind • Lives in nursing home
Example of care plan considerations for progression of diabetes	✔ Preventive screenings and immunizations ✔ Patient education and engagement ✔ Appropriate monitoring for warning signs ✔ Health and social risk assessment (annual) ✔ Care plan that includes smoking cessation counseling and program offered ✔ Diet and exercise education		✔ Recommended preventive screenings and immunizations ✔ Appropriate monitoring for HbA1c, microalbumin, LDL ✔ Patient education and engagement for medication adherence, diet, and exercise ✔ Home self-monitoring for blood glucose ✔ Smoking cessation counseling ✔ Refer to Diabetes Self Management Education (DSME) program ✔ Care manager/coordinator visits to manage rising risk ✔ Diabetes group visits ✔ Referrals as appropriate ✔ Community resources, such as the YMCA or prescription drug assistance programs ✔ Health and social risk assessment (semi-annual)		✔ Recommended preventive screenings and immunizations ✔ Appropriate monitoring for HbA1c, microalbumin, LDL ✔ Patient education and engagement for adherence to care plan and medications ✔ Diabetes group visits ✔ Regular visits with care manager/ coordinator ✔ Home health for wound care ✔ Physical therapy for mobility ✔ Care coordination with specialist and other services	✔ Rehabilitation after hospitalization ✔ Skilled Nursing Facility ✔ Palliative or hospice care ✔ Individualize intensive care management and coordination by care manager/coordinator ✔ May or may not conduct preventive screenings ✔ Health and social risk assessment, as appropriate

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