Risk-Stratified Care Management and Coordination

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Table 1: Example of Potentially Significant Risk Factors to be Considered when Assigning Risk Levels

Clinical Diagnoses, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization	Clinician Input (Personal Knowledge)
• Any chronic disease, particularly that is not at desired goal • Multiple co-morbidities • Chronic pain • Substance abuse • Behavioral health diagnosis • Terminal illness • Advanced age with frailty • Pre-term delivery of newborn • Patients with special needs • Dental health • Dementia/Alzheimer's Disease	• Non-ambulatory • Needs Assistance with Activities of Daily Living (ADLs) • Severely diminished functional status • Declining eyesight • Extreme weakness or fatigue • At risk for falls	• Lack of financial support • Lack of family support that impacts care • Unemployed • Homelessness • No health insurance • Low health literacy • Unsafe home environment • Lack of transportation • Language barriers • Lives alone	• Frequent hospitalizations • Frequent ER or urgent care visits • Multiple providers • Hospital readmission within 30 days • Major procedure in last year • Chronic kidney disease • Brain trauma • Expensive medications	• Polypharmacy • High-risk medications • Difficulty following treatment plan • Difficulty taking medications as prescribed • Recent visit to a long-term facility or other transition of care • Spouse recently deceased • Low confidence or ability for self-management • Answer the question: Is this patient likely to be hospitalized in the next 30 days?

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: To prevent onset of disease (Low Resource Use)	GOAL: To prevent onset of disease (Low Resource Use)	GOAL: To treat a disease, reduce rising risk, and avoid serious complications (Moderate Resource Use)	GOAL: To 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 • Health risk assessment (annual) • Appropriate monitoring for warning signs	**CARE PLAN SUGGESTIONS** • Preventive screenings and immunizations • Patient education and engagement • Health 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 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 care management, 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 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 care management, 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 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: To prevent onset of disease		SECONDARY PREVENTION (Moderate Resource Use) GOAL: To treat a disease, reduce rising risk, and avoid serious complications		TERTIARY (High Resource Use) GOAL: To 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 • Premature baby (May have high costs with limited or no opportunity for improvement, stabilization, or cost control)
Example of using uncontrolled progression of diabetes	• Healthy	• Blood glucose and lipids rising, but still within desired parameters • BMI elevated • Smoker	• Diagnosed with type 2 diabetes, blood glucose, and lipids brought within desired parameters • Married, family involved	• Blood glucose and lipids not within desired parameters, and financial situation impacting negatively • 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 Activities of Daily Living (ADLs)	• 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 patient with uncontrolled progression of diabetes	✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring for warning signs ✓ Health risk assessment (annual) ✓ Care plan that includes smoking cessation counseling and program offered		✓ 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 and 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 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 management ✓ Physical therapy for mobility ✓ Care coordination with specialist and other services	✓ Rehabilitation after hospitalization ✓ Long-term care ✓ Hospice for lung cancer ✓ Individualize intensive care management and coordination by care manager/coordinator ✓ May or may not conduct preventive screenings ✓ Health risk assessment, as appropriate

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