Patient Identification for CM Services

Trigger List

Low Risk	Moderate – Rising Risk	High Risk
Single disease management condition with no recent exacerbations	Perspective score of X	Perspective score of X
Chronic condition with 1-2 out-of-scope quality measures Example: DM and missed HbA1c test, no PCP visit in last year	High cost claims ($50,000 as a starting place)	Current/recent unplanned admission (w/n last 4 weeks)
Uncomplicated financial barrier or care coordination need	Co-morbid disease management condition with out-of-scope measures including: Diabetes, heart failure, COPD, osteoarthritis, coronary artery disease, cardiovascular, peripheral vascular disease	Patient with 2 or more chronic conditions with out-of-scope measures, chosen by the delivery system as critical for its population
Patient education and or self-management reinforcement/update need	Heart failure and or COPD with recent exacerbation (hospital stay, ER visit within last year)	Patient with a chronic condition and social determinant issue, or where a high need is required immediately
	Stage 4/5 CKD	A patient with a chronic condition and a behavioral health exacerbation
	Acute medical condition requiring care coordination and/or monitoring (pneumonia, wound, cellulitis)	Dual eligible (Medicare and Medicaid)
	Pt referred by provider as potential candidate	Pt referred by provider identified as high risk for an exacerbation

Note: This document was developed by Mi-CCSI after reviewing guidance from a leading integrated delivery network/health plan, as well as input from the literature and work teams facilitated by Mi-CCSI. Your system may provide other guidance.