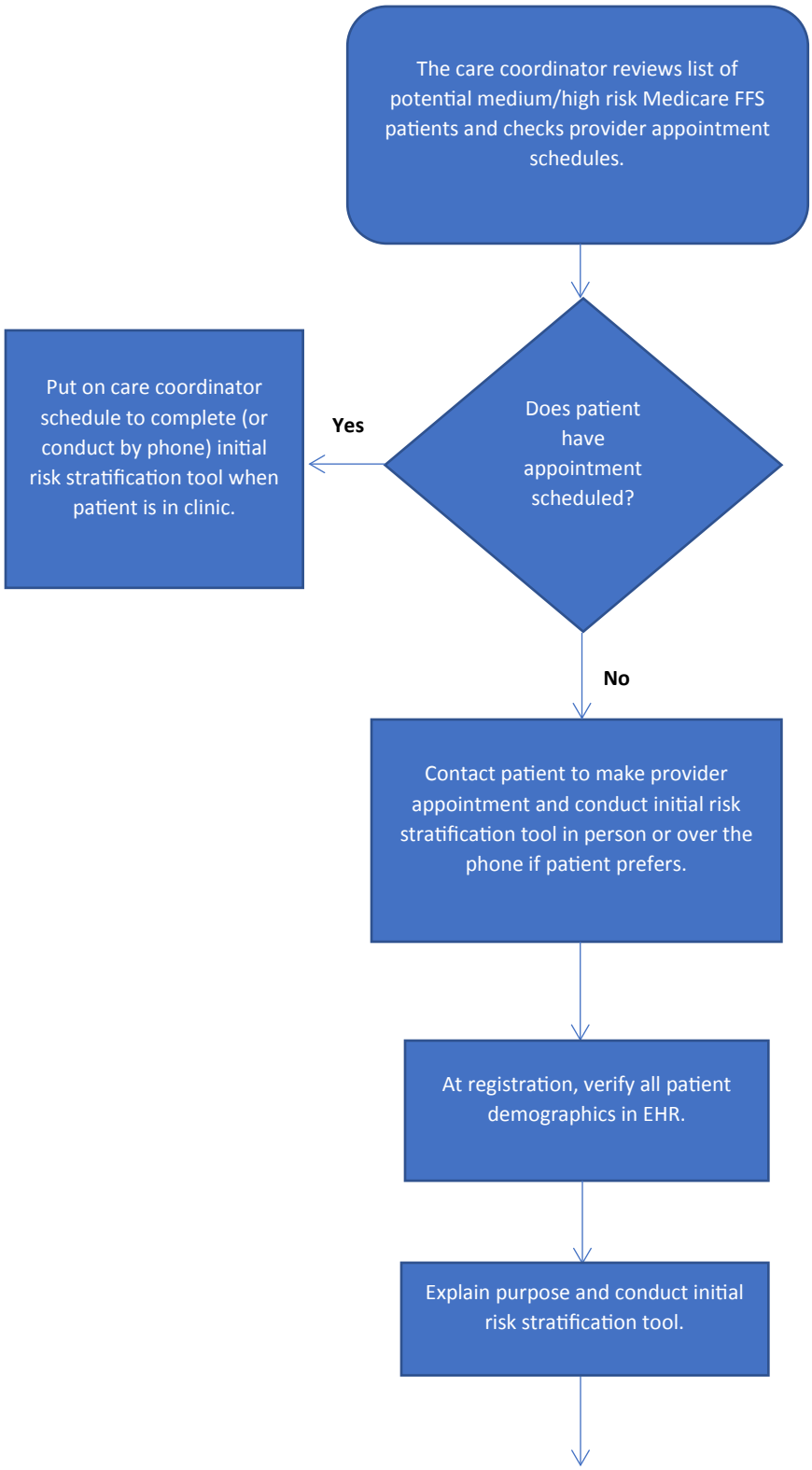
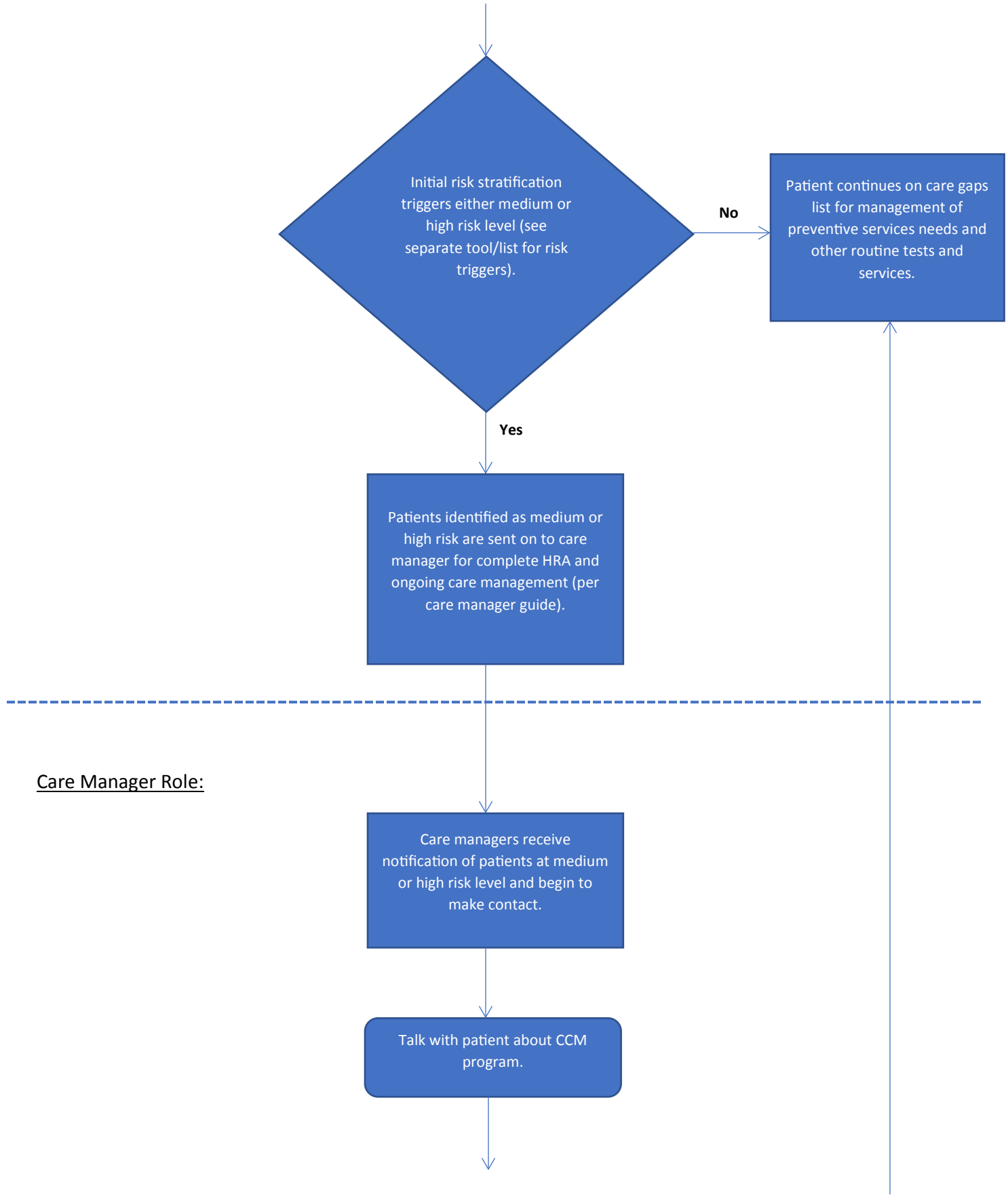
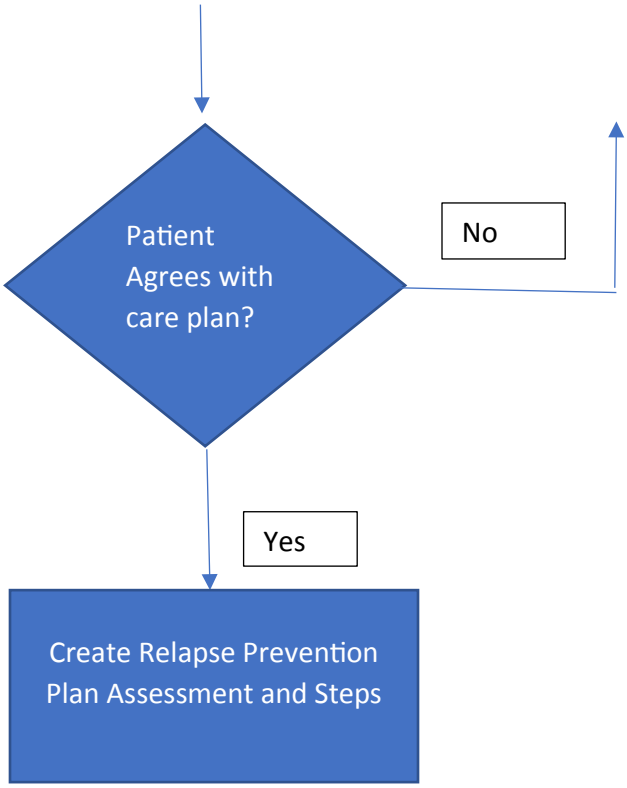
# OVERALL INCLUDING RELAPSE PREVENTION CARE MANAGEMENT FLOW CHART

Care Coordinator Role:




Initial risk stratification triggers either medium or high risk level (see separate tool/list for risk triggers).
No
Patient continues on care gaps list for management of preventive services needs and other routine tests and services.
Yes
Patients identified as medium or high risk are sent on to care manager for complete HRA and ongoing care management (per care manager guide).
Care Manager Role:
Care managers receive notification of patients at medium or high risk level and begin to make contact.
Talk with patient about CCM program.


Patient consents to CCM program.
No
Patient continues with usual care but will have new contact to reengage based on new clinical trigger event.
Yes
Make appointment with CM for longer visit and conduct comprehensive assessment.
Complete the HRA (per instructions in CM manual).
Using information from comprehensive HRA, review with PCP and begin development of patient care plan.
Monthly care manager follow-up contracts with patients that are at high risk (more frequent if needed). Follow-ups have minimum of 3 areas:
Review meds and side effects (other tx changes
Review any new labs/appts./ED/Hosp
Review self-management goals and progress
Review and discuss any routine labs, tests, services needed to regularly monitor progress for each chronic medical condition
Every 2-3 months follow-up contacts with care manager for patients that are at medium risk. Follow-ups have minimum of 3 areas:
Review meds and side effects (other tx changes
Review any new labs/appts./ED/Hosp
Review self-management goals and progress
Review and discuss any routine labs, tests, services needed to regularly monitor progress for each chronic medical condition
Meet with PCP (and other care team members as needed) and get input and PCP sign-off on care plan.
Triggers to meet with care team:
Review new CM patients
Review CM patients not making improvements or recently hospitalized/ED
Review care plan started and add from other care team members


Patient Agrees with care plan?
No
Yes
Create Relapse Prevention Plan Assessment and Steps