Risk-Stratified Care Management and Coordination

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Table 1: Examples of Potentially Significant Risk Factors

Clinical Diagnoses, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization/Claims Data	Clinician Input (Personal Knowledge)
– Any chronic disease, particularly one that is not in control or at desired goal – Chronic pain – Substance abuse (alcohol/drug/tobacco) – Terminal illness – Advanced age with frailty – Multiple co-morbidities – Pre-term delivery of newborn – Child, youth, or adult with special needs – Anxiety, schizophrenia, bipolar, depression, or other behavior affecting health – 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 or family support that impacts care – Unemployed – No health insurance – Low health literacy – Unsafe home environment – Homeless – Lives alone and needs assistance with ADLs – Transportation for health care appointments is difficult – Language barriers	– Frequent hospitalizations (particularly heart failure, GI disorders, and pneumonia) – Frequent office, 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 – Patient is taking several medications that may not all be needed and/or could have potential for interactions – High-risk medications – Non-compliant with treatment plan – Confusion with medications or following the treatment plan – Recent move to long-term facility or other transition of care – Spouse (who was the caregiver) recently deceased – Lack of engagement in care plan – Low confidence or ability for self-management – Answer to the question: Is this patient at higher risk for dying within the next year?

Table 2: 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 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**
	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 sugar, and lipids brought within desired parameters • Married, family involved	• Blood sugar and lipids not within desired parameters, and financial situation impacting negatively • 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 • 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		✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring ✓ Health risk assessment (semi-annual) ✓ Care plan with smoking cessation counseling and program offered ✓ Team/planned care ✓ Group visits ✓ Health coach ✓ Referrals as appropriate, such as social services ✓ Community resources ✓ Home self-monitoring		✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring ✓ Health risk assessment (quarterly) ✓ Intensive care management plan and resources ✓ Smoking cessation ✓ Group visits ✓ Health coach ✓ Home health	✓ Hospitalization ✓ Rehabilitation ✓ Long-term care ✓ Hospice ✓ Home health ✓ Individualized intensive care management and coordination ✓ May or may not conduct preventive screenings ✓ Health risk assessment, as appropriate

Identifying Disease Burden and Determining Health Risk Status

Is the patient healthy, with no chronic disease, or *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 and avoid serious complications (Moderate Resource Use)**	**GOAL: To treat a disease 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