**Protocol: Care Management Model for High-Risk Patients**

This protocol outlines our health center’s Care Management Program for high-risk patients. The intent of this protocol is to create a standardized and integrated process for care management that addresses chronic care and preventive care needs that achieve results sustained over time.

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| **Risk Stratification**Use the *Risk Stratification Action Guide* to segment patients into target groups based on the number of clinical conditions. * Generate a list of all patients 18 years of age and older attributed to the target site
* Match this list of patients against selected UDS diagnoses (p. 3, *Risk Stratification Action Guide*)
* Leverage data on the selected diagnoses and determine risk level
* Separate targeted patient population into four risk groups
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| **Identify Individuals**Utilize the *Care Models: Risk-Based Action Guide*to develop models of care targeted to the unique needs of each target group (high, rising, and low-risk). Target interventions to match the unique needs of each risk group, including high-risk. Determine the criteria for including patients in the Care Manager led High-Risk Care Management model. * Establish a target caseload for RN Care Manager
* Determine the number of high-risk patients identified through stratification
* Triage the high-risk group to build desired caseload
* Prioritize patients who do not meet the evidence-based guidelines/standards for colorectal and/or cervical cancer screening
* Define criteria for patients referred by the care team who are deemed high-risk but do not meet the risk stratification criteria
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| **Outreach and Pre-Visit Planning*** Introduce patient/family/caregiver(s) to Care Manager (e.g., *Telephone Script ● Patient Handout*)
* Confirm participation in Care Management
	+ Decline - Document and PCP Communication
	+ Accept - Pre-visit planning
* Review medical record
	+ Identify gaps in evidence-based standards for each chronic condition
	+ Identify gaps in preventive health, evidence-based standards and screening, prioritizing colorectal and cervical cancer screening
	+ Identify needed labs
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| **Initial Planned Care Management Visit**Utilize *Care Management for High-Risk Patients Action Guide* to create a standardized approach for the management of high-risk patients by an RN Care Manager.* Agreement to participate (Signature recommended)
* Comprehensive assessment/evaluation
* Depression Screening
* Medication Reconciliation
* Labs ● Screening
* Specialist ● Community Referrals
* Care Plan ● Goals
* Self-Management ● Barriers ● Action Plan
* Education
* Visit Frequency
* Follow-up Appointment
* PCP Communication
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| **Follow-up and Management**Use the *Care Management Worksheet* to document and track Care Management caseload.* Care Plan ● Goals
* Self-Management ● Barriers ● Action Plan
* Education
* Medication Reconciliation
* Labs ● Screening
* Specialist ● Community Referrals
* Visit Frequency
* Follow-up Appointment
* PCP Communication
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| **Case Closure** *Gaps closed ● Goals Met ● Non-Participation** Care Team ● PCP ● Leadership discussion
* Patient/family/caregiver(s) discussion
* Medical record documentation
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