**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 |