**COMPLEX CARE MANAGEMENT MODEL**

Practices that develop a standardized and integrated care management process for ensuring chronic care and preventive care needs are addressed will achieve results that can be sustained over time.

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| **Risk Stratification**  Referencing the *Risk Stratification* Action Guide, segment patients into target groups based on the number of conditions per patient (see stratification table within Guide).   * Generate a list of all patients 18 years of age and older attributed to the target site * From this list, identify those with target conditions/screening (colorectal or cervical cancer screening, HTN, diabetes, obesity, and depression). * Separate this population into four risk groups (low, rising, high and highly complex) |

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| **Identify Individuals**  Utilizing the *Care Models: Risk-Based* Action Guide,identify individuals within the high risk group to be targeted for care management.   * Establish target caseload for RN Care Manager * Triage high-risk group to prioritize outreach and recruitment into care management * Include in prioritized group, patients due for colorectal and/or cervical cancer screening * Define criteria for care team referral of individuals deemed high-risk but do not meet established criteria |

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| **Outreach and Pre-Visit Planning**   * Introduce patient/family/caregiver(s) to care management * Confirm participation in Care Management * Decline - Document and PCP Communication * Accept - Pre-visit planning * Medical record review * Gaps in evidence-based standards for each chronic condition * Gaps in preventive health evidence-based standards, prioritizing colorectal and cervical cancer screening * Needed labs/screening |

**Developing a Comprehensive Care Management Model**

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| **Initial Planned Care Management Visit**   * Agreement to participate * Comprehensive assessment/evaluation * Depression Screening * Social Risk Assessment (coming in the Fall 2017) * 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**   * 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 * Patient/family/caregiver(s) discussion * Medical record documentation |

**Tools ● Templates ● Resources**

Michigan Care Management Resource Center

<http://micmrc.org/care-management-101>

American Medical Association (AMA)

<https://www.stepsforward.org/modules/pre-visit-planning>

Institute for Healthcare Improvement (IHI)

<http://www.careredesignguide.org/>

U.S Preventive Services Task Force (USPSF)

<https://www.uspreventiveservicestaskforce.org>

American Diabetes Association - 2017 Clinical Guidelines

<http://www.diabetes.org/newsroom/press-releases/2016/american-diabetes-2017-standards-of-care.html?referrer>

Clinic Health Coach,” Transform the Conversation. Transform the Care.”

<http://clinicalhealthcoach.com>