**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
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**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
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**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>