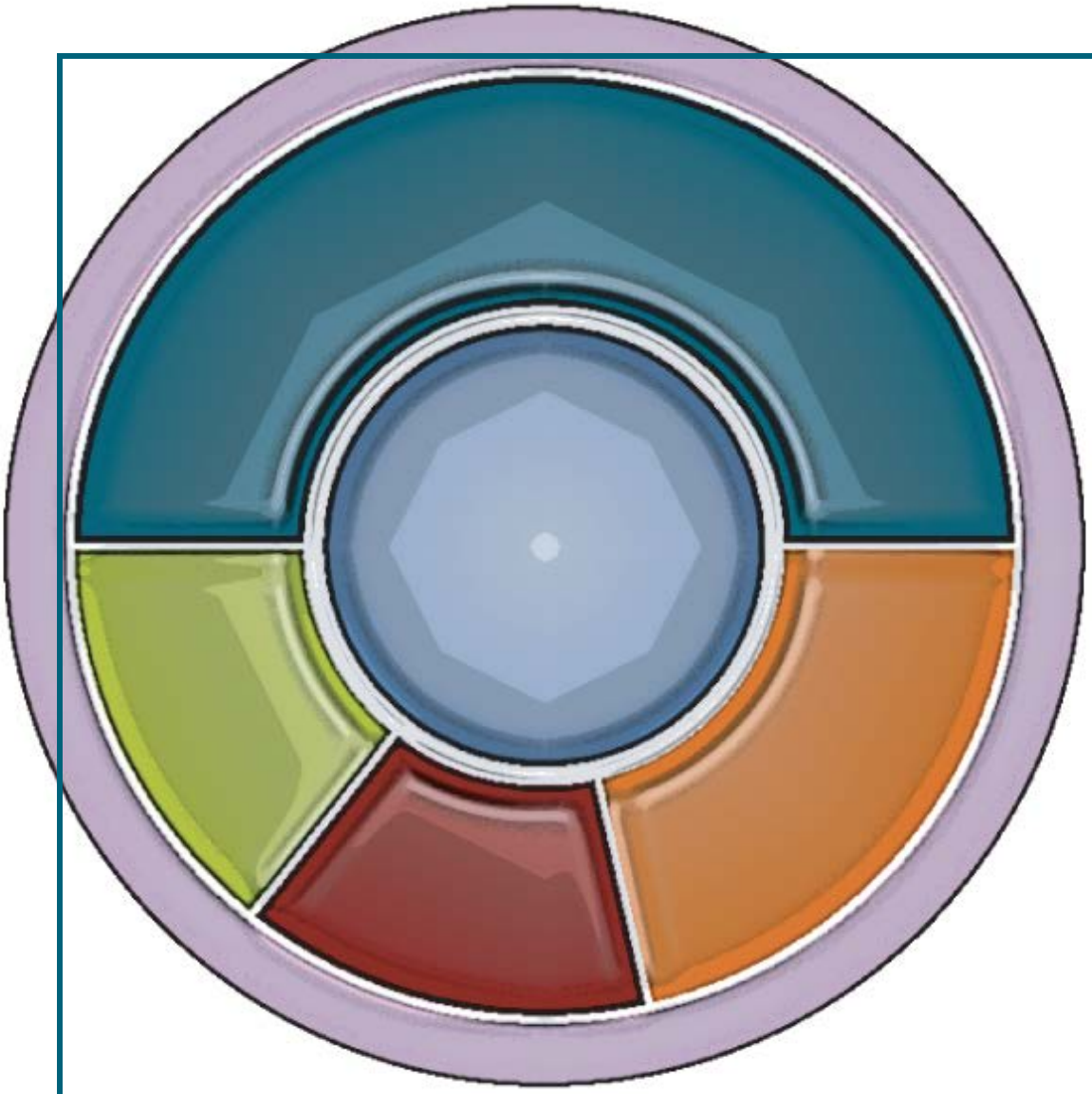


Care Management:
A Review of CPC Practice Approaches

June 2014

CPC
Comprehensive Primary Care

An Initiative of the Center for Medicare & Medicaid Innovation

Care Management:
A Study of CPC Practice Approaches

Table of Contents

Purpose of this Guide 3

Overview of the Care Management Component in Milestone 2 4

Essentials of Care Management of High-Risk Patients *4*

Care Management versus Care Coordination *4*

Reporting for PY 2014 5

CPC Practice Approaches 5

Case Studies ..... **Error! Bookmark not defined.**

Designated Care Manager *6*

Finding the Right Designated Care Manager *7*

Implementing Designated Care Managers *8*

Training Care Managers *9*

Using a Team Approach *10*

Assigning Duties in a Care Management Team *10*

Care Management Teams Working with Care Coordinators *13*

Embedding Care Management into Workflow 14

Conclusion 16

Resources 17

Care Management *17*

Empanelment *18*

Appendix 19

Job Descriptions *19*

Clinical Workflows *26*

Risk Stratification Tools *27*

References 32

TMF Health Quality Institute

This material is presented by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

Purpose of this Guide

This guide reflects on how CPC practices across the country have approached the care management component of Milestone 2. These practice strategies represent samples of the work and are not representative of every strategy for implementing robust care management in a practice.

CPC practices are heterogeneous in size, geography, ownership and organization; they are encouraged to innovate and test strategies derived from evidence-based and/or best practices, and customize the work according to their particular needs, local dynamics and other practice aspects that may shape how they deliver care management services.

This Guide captures the energy, innovative ideas and rigorous and determined execution of the CPC practices as they test and implement care management in their practice. Through this Guide we hope you find in your colleagues' work the support for implementing Comprehensive Primary Care.

June 11, 2014

Overview of the Care Management Component in Milestone 2

Milestone 2: Population Health and Care Management for High-Risk Patients addresses population health, with a priority of focus on those at highest risk for poor outcomes and preventable harm. In Program Year (PY) 2013, practices engaged in routinely assigning risk status to all empanelled patients through a risk stratification methodology and built care management capacity into their care teams to address outreach and intense intervention needs of those patients identified at highest risk. Effective Care Management results from a complex exercise of clinical judgment. It happens as relationship-based engagement with a care team that is proactive, longitudinal and focused on meeting the patient's clinical and health care needs is built. The ultimate goal is to work with the patient to meet his or her health care goals.

Steps before Care Management:

1. **Empanel patients using EHR**
2. **Develop risk stratification methodology**
3. **Develop care management strategy**
4. **Build care management capacity into care teams**

Essentials of Care Management of High-Risk Patients

1. Plan of Care

A mutually agreed upon and documented plan of care based on the patient's goals

2. Evidenced-Based Pathways of Care

Planned and documented pathways of care based on best available evidence and guidelines for care in the unique context of the individual patient

3. Proactive Delivery

Do not wait for visits or acute decompensation – this is not primarily visit-based. Patient visits are opportunities to define goals, plan care, engage in Shared Decision Making and build a trusting relationship, but most care management activities take place by phone, email or home visits (as well as visits to SNFs or hospitals to support transitional care). These activities are appropriately targeted based on patient needs.

4. Team-Based Approach

Care management includes dedicated clinically trained staff working closely with the physician in a team-based approach to care for individuals with complex health needs. Staff is typically in the nursing or social work disciplines but occasionally from other disciplines such as pharmacy and dietetics.

5. Care Management Documentation

Documented activities are included the medical record with input to capture critical information. These include the nature and substance of the contact, assessment of current status, changes to the care pathway or overall care plan, unresolved questions and next scheduled follow-up contact.

Care Management versus Care Coordination

Care Management is distinct from Care Coordination, which in CPC refers to the organization of care both within the practice and between the practice and community settings, labs, specialists and hospitals. Care Coordination activities include closing care gaps, coordinating care between transitions and reducing fragmentation.

Care Management activities are person-focused, ensuring individuals at high risk get the care they need and desire, and Care Coordination activities are system-focused, ensuring that care is seamless across providers and transitions.

Care Management versus Care Coordination

Care Management	Care Coordination
• Person-focused • Organization of care within a practice and between health organizations • Ensure individuals are getting the care they need	• System-focused • Closing care gaps by coordinating between transitions and reducing fragmentation • Ensure seamless care across providers and transition

Reporting for PY 2014

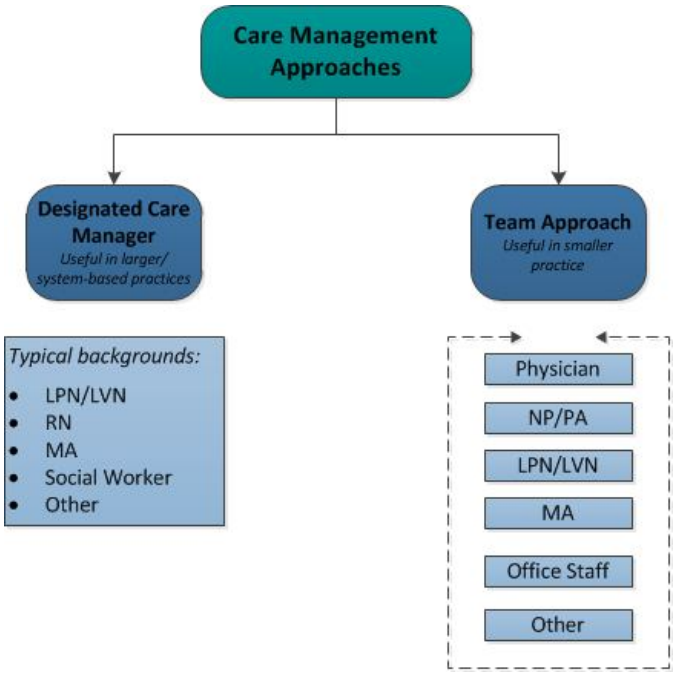
Practice-based empanelment, risk stratification and care management will remain an essential part of CPC throughout the program. While practices will work toward achieving **risk stratification of 75 percent of empanelled patients,** the care management target is to **provide care management to at least 80 percent of patients identified as those at highest risk**: those that are clinically unstable, in transition and/or otherwise need active, ongoing, intensive care management. Quarterly reporting will include updating information about the practice's care management staffing and activities. (Complete reporting requirements for this work are described on page 13 of the 2014 Implementation Guide.)

Achieving a successful balance for effective care management may require adjustments over time. If the number of patients in the highest risk cohort is disproportionately large, the risk stratification process may not be discriminating enough, calling for a more narrow definition to meet the patients' care management needs adequately. Similarly, if the risk stratification method is too narrowly defined, opportunities to identify and care-manage some patients may be missed. Using the PDSA cycle, a practice can further refine the risk stratification process to help ensure the highest risk cohort has a proportional distribution of empanelled patients. Furthermore, the patient caseload must align with the care management resources to ensure timely and appropriate services. Finally, tracking the care management interventions is essential for identifying gains in key data points such as fewer hospitalizations, reduced ER visits and better health. This facilitates movement of patients from a high-risk stratum to a lower risk stratum. Each of these key components work in tandem with each other, and practices will need to carefully plan their approaches and tests for effectiveness to make the most timely gains.

CPC Practice Approaches

The CPC initiative encourages practices to develop creative, innovative solutions to achieve the three aims of better health, better care and lower cost. As a result, CPC practices have undertaken diverse approaches to care management implementation. Several practices have chosen to hire a designated care manager whose primary responsibility is to address care management specifically, while others have taken a team approach by dividing portions of the care management responsibilities among existing team members. In both models, there is a net increase in time spent managing the care of complex patients.

Care managers across CPC represent a spectrum of backgrounds from registered nurses (RN), social workers (SW), licensed practical nurses (LPN), medical assistants (MA) and medical office assistants (MOA). In the case of some smaller practices, the providers (physicians, nurse practitioners [NP] or physician assistants [PA]) have also assumed the bulk of care management responsibilities.



In general, smaller practices tended to hire MAs or LPNs for this role, while larger multiple-provider practices usually hired RNs as care managers. Some of the larger system-based practices have centralized care management by housing and training care managers in one location for all the practices in the system. In some instances, the care managers are located onsite within the practices after completing the initial training. Is it important to note that some CPC practices use the terms care management, case management, health coach and care coordinator interchangeably. The semantics are not as important as identifying the care management responsibilities each role performs.

To best illustrate the diversity of CPC practices' approaches to care management, this Guide provides a sampling from CPC practices across the regions. These case studies demonstrate how innovation can vary within CPC. As you examine these practice stories, keep in mind that each practice should determine the best approach for its practice, culture and patient population.

Case Studies

In the following case studies, CPC practices explain how they provided care management services to best meet the needs of their patient population.

Designated Care Manager

Many CPC practices across the United States have hired a care manager to implement care management successfully. Designated care managers are motivated and focused on resources devoted to helping patients achieve their health goals. This approach is more common in larger practices that can devote a FTE to care management duties. Smaller practices can also work together to share a designated care manager. The following case studies highlight how CPC practices recruit, hire, train and on-board designated care managers as well as work with care coordinators.

Finding the Right Designated Care Manager

Summit Medical Clinic, Colorado Springs, Colorado
Independent; one physician, one PA, two ANPs; 3,000 patients

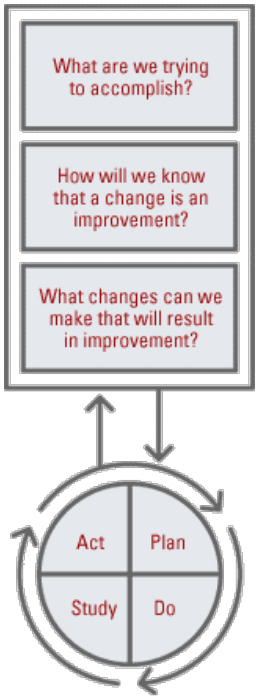


Figure 2: PDSA Cycle
Refer to Improvement Basics webinar (Oct. 23, 2013) for additional information about how to design and apply PDSA cycles to your work.

While some practices began the care management journey with a designated care manager, other practices arrived at that solution after several iterations of PDSA cycles, like **Summit Medical Clinic** of Colorado Springs, Colorado. Following the best tenets of practice transformation, Summit used PDSA cycles to test care management activities in its practice, eventually finding a dedicated care manager was the best fit for the practice. Summit's care management strategy stems from ongoing empanelment and risk stratification of patients.

PDSA 1: Early in the work, the practice hired a medical assistant to serve as the care manager and care coordinator. However, Summit found that a high-level MA lacked the training and skills to be an effective care manager. The practice revised the focus of the MA's work to population management, including generating reports for the practice, with some follow-up calls to high-risk patients between visits.

PDSA 2: The higher level care management responsibilities shifted to the providers with the goal of seeing all high-risk patients. Providers each carved out three hours per week for chart review on high-risk patients and conferenced with their MA and the care coordinator as needed. Again, while this brought the needs of the patients to light, this effort did not meet their expectations because patients were generally unavailable for appointments during the three-hour blocks.

PDSA 3: The practice then set up weekly visits focused on care management during a three-hour block of time. For these patients, the provider created a patient-focused care plan that included short- and long-term goals. This model proved to be an ineffective use of provider time as each appointment tended to last at least 45 minutes. The pace made little progress toward achieving the practices' goal of seeing all high-risk patients.

PDSA 4: The final PDSA led the practice to hire a full-time RN care manager and assign a care coordinator (complete job descriptions for these two roles can be found in the Appendix). Since hiring the care manager, the clinical workflow (see the Appendix for details) appears to work well for the practice. The care manager has an identified panel of 155 patients who are at high risk and a goal to engage each of these patients in active care management.

Designated Care Manager: Selected Best Practices

1. Develop robust job description
2. Build consensus on particular issues
3. Get buy-in from staff
4. Re-arrange workflow

Summit Medical Clinic is now testing a collaborative care plan process. This team approach introduces the patient to the care management program through the provider's warm handoff to the care manager. Currently, the RN care manager meets with patients, between or in conjunction with primary care visits, in the office, at their home and over the phone. As part of this program's continued growth, the practice

intends to add email communication as a component of care management in 2014. The care manager is also responsible for calling all care-managed patients after hospital discharges or ED visits for follow-up care and appointments, as needed. The care coordinator is primarily responsible for overall population management, coordinating follow-up care for patients in the lower risk categories after hospital discharges or ED visits, and management of reports such as clinical quality measures (CQM) and utilization measures (UM). Each provider's MA is responsible for pre-visit chart review/update and tracking referrals, labs and tests.

Implementing Designated Care Managers

Baptist Health Family Clinic, Bryant, Arkansas
System based; three physicians, one ANP; 6,000 patients

Baptist Health Family Clinic in Bryant, Arkansas, found the implementation of dedicated care management to be an exciting and rewarding aspect of CPC. The addition of the care managers and the staff's increased awareness and knowledge of care management have allowed the practice to provide more intensive care management by helping patients identify their self-care goals, developing care plans for those patients and effectively following up on their progress. This practice's leadership feels that patient experience of care improves when patients are able to sit down with someone during their visit to develop a personalized self-management plan.

This practice realized that by employing a range of staffing levels for care management roles, the likelihood of improved communication with patients increased. Some patients who are reluctant to ask questions of primary care providers may be more open and receptive to communicating freely with the care management staff, including discussing their barriers to care or concerns about treatment.

Baptist Health's care management workflow begins when a patient checks in. The nurse or MA updates completion of any routine screenings or tests, reconciles the medication list with the patient and updates social, surgical and past medical history. This practice emphasizes accurate medication reconciliation as a critical step. The providers and care facilitators update risk status and, if a patient is due for preference-sensitive preventive screenings, they provide decision making aids to the patient. If the nurses and providers recognize a need for more intensive care management, they refer the patient to a care manager for a same-day or scheduled appointment.

Care managers provide support to patients living with many chronic health conditions such as diabetes, hypertension, hyperlipidemia, COPD and asthma management. If a patient may benefit from home health, the care manager initiates this level of care. They assist patients with access to medications, meals, medical equipment and some specialists. The care managers also work with patients to develop patient-focused care plans for their chronic conditions.

Baptist Health has found that its efforts in care management are improving outcomes. The practice's focus for PY 2013 was to improve hemoglobin A1c results among patients with diabetes. In the summer of 2013, a provider diagnosed diabetes in a patient who was in her late sixties. The patient met with a care manager on the day of the diagnosis and set a personal goal to lose 30 pounds by using the Plate Method, a basic method to eat healthfully with diabetes, along with starting to exercise regularly and adhering to a regimen of oral diabetes medication. She attended evening education classes about diabetes at the practice and

learned how to check her blood sugar daily. Six months later, the patient had lost 28 pounds and dropped her A1c from 8.5 to 6.6. She told staff she felt empowered because she received support for learning how to take care of herself and manage her diabetes. The care management program further bolstered her confidence in disease management because she learned when she should call the clinic to address concerns or questions. If she called, she knew someone would take the time to talk with her and resolve her concerns.

> *"She feels empowered because she learned how to take care of herself with diabetes."*

Since beginning intensive care management in 2013, Baptist Health Family Clinic's data shows improvement in A1c levels among the entire empanelled patient population who have diabetes.

Training Care Managers

St. John Clinics, Sapulpa, Oklahoma
System; three physicians, one ANP; 5,378 patients

St. John Clinic of Sapulpa is a part of the St. John Clinics in Tulsa, Oklahoma. The care management program is centralized within the St. John Clinics system. They hired primarily RN care managers, following the suggested staffing plan found in several care management resources.

The St. John Clinics began their journey toward care management with only medical assistants and used the CPC Regional Care Management Webinar to learn about hiring guidelines and duty assignments as well as how to establish a process for identifying high-risk patients. The number of care managers needed was determined by evaluating a physician's panel and estimated 10 percent of the patients to a care manager, based upon findings in the literature. However, this strategy proved ineffective for St. John. Using the AAFP risk stratification model, the practices focus the care managers' efforts on patients in category 5 and 6. This calculation netted each care manager an average of 750 patients. They attribute this disproportionate number to low socioeconomic status, and low education level among their population. St. John Sapulpa has one care manager, with 943 patients that are risk 5 and 116 patients that are a risk 6, which makes a total of 1,059 patients identified as needing intensive care management.

St. John Clinics hired a central care manager to help identify the target patient population, a decision the practice insists was their best during the implementation of care management. The central care manager was housed in a vacant suite at one of the practices. As other care managers were hired, they would work at that office for training. The central care manager trained new care managers on the risk stratification tool and validated that they could use it properly. While it was tedious work to sit in a room and risk stratify patients, an unexpected benefit emerged. The care managers developed relationships that they have maintained after they were "deployed" to their individual clinics. They also see the central care manager as the leader, although they technically report to their clinic's practice manager.

Currently the central care manager represents the St. John Clinics at readmissions meetings with their system hospitals as well as at the CPC group meetings outside their health system. Each month the central care manager meets the practice managers and other site-based care managers for a check-in, to keep communication flowing and to discuss points of interest or concern (e.g., care plans, CPC-related activities, etc.). St. John envisions the role of care managers will continue to change and grow as the system's

workflows evolve. It is expected that more care managers will be added as the new workflows are established.

Using a Team Approach

Rather than hiring one or two staff that solely focus on care management, some practices have chosen to implement a team approach where each team member takes responsibility for some aspect of the overall care management program. The team approach incorporates the multidisciplinary specialties of individuals working in the practice to help provide care management for the patients. Many smaller practices have chosen the team approach. The examples described here show effective care management is possible in the small practice. The following practices' stories illustrate use of multidisciplinary care management strategies.

Assigning Duties in a Care Management Team

Village Primary Care, Hoosick Falls, New York
Independent; two physicians, one ANP; 4,689 patients

Village Primary Care, a small, rural practice in Hoosick Falls, New York, has adopted a team approach to care management. CPC funding was used for a part-time RN nurse case manager, a part-time diabetes educator, a transitional care nurse and an MA. The practice combined roles to provide comprehensive yet efficient use of the disciplines. The MA manages the patient panel, working from reports and directly with patients to arrange needed health care services. The RN is a contracted care manager who works with high-risk patients to develop and implement care plans in conjunction with the primary care provider. The diabetes educator is contracted two and half days per month to work with at-risk patients with diabetes in both one-on-one and group settings.

Due to the practice's rural location, most patients use one hospital, Southwest Vermont Medical Center, and a transitional care nurse is contracted 16 hours per week to work with high-risk patients upon discharge from that facility. The transitional care nurse works at the hospital and coordinates patient care upon discharge with a warm hand-off to the RN care manager in the practice (see an example of the workflow in the Appendix). The role of the transitional care nurse focuses more on care coordination across the medical neighborhood instead of traditional care management, similar to the traditional case manager role in the hospital setting. Practices seeking to follow this strategy may want to attempt to recruit ideal candidates from current hospital case managers.

Hudson Valley Primary Care, Wappingers Falls, New York
Independent; two physicians, two ANP; 8,290 patients

Hudson Valley Primary Care in Wappingers Falls, New York, also uses a team approach to care management and coordination with duties designated to the appropriate discipline. The care team "huddles" regularly and uses a physician, a NP, a RN, a LPN and administrative support for a combined set of activities focused on ensuring a coordinated system of care for all patients. The full-time RN is certified in care management and has nine years of clinical nursing and three years of experience working in a primary care medical home. She supports the patients in the highest risk strata, and her typical case load consists of approximately 1 to 2 percent of the practice's patient population. Essential activities of the nurse care manger include managing transitions of care, completing medication reconciliation, providing self-

Huddles:
The huddle is an informal meeting that occurs at the end and beginning of the day where the provider, nurse and secretary review the patients as a team. The nurse looks at the chart to see why the patient is coming in, inserts the correct templates and uses order sets to enter the correct labs. Then, the nurse confirms the patient is up to date with all preventive screening and vaccinations and flags the chart to indicate if they need anything. The nurse also reviews same day appointments to make sure that these patients are up to date with their chronic disease management. If the patient is a case-managed patient, the nurse will then communicate with the RN CCM to allow time for the RN CCM to meet with the patient. The provider and the nurse will complete the huddle in the morning before starting appointments but also may huddle throughout the day to ensure that all the patients' needs are being addressed. The nurse also reviews referrals that have been outsourced to specialists and makes sure that the consult is in the chart for the providers.

management support and developing individualized care plans with patients. In addition to clinic huddles, the team has regular medical home meetings where the nurse care manager can alert and provide details to the full team about patients of concern. The monthly medical home meetings cover the CQMs and review patient experience results. The team also reviews all the patients who have been in the hospital and the ER to see if an admission could have been prevented. Patient-centered care plans are part of the EHR and are printed and provided to all high-risk patients at the end of each visit.

Upper Valley Family Care, Troy, Ohio
Independent; six physicians, two ANP; 12,485 patients

One individual performing all the tasks required of the care manager may not be sufficient for a practice based on size or that has high levels of risk in the patient population. **Upper Valley Family Care** in Troy, Ohio, divided the care manager role between these two FTEs and titled them health coach and transitional care coordinator. This practice began by developing a job description for a health coach and transitional care coordinator and made the decision to contract these new positions.

In this practice, the role of the health coach performs care management for the low-risk population while the care coordinator performs the role of external care coordination across the medical neighborhood, as well as care management of the high-risk population. They share duties fluidly, with the health coach focusing on helping patients attain the knowledge, skills, tools and confidence to become effective participants in their care so they can reach their self-identified health goals. They work with patients at all risk levels, encouraging them to obtain regular preventive health care and assisting patients in setting simple goals toward achieving better health.

The care coordinator in this practice provides care coordination for Upper Valley patients identified as being at higher risk according to the AAFP stratification scoring tool. The care coordinator develops and monitors care coordination processes by first identifying the high acuity patient population or receiving a referral from the care team. The care coordinator implements specific care planning activities, assisting patients with goal setting and self-management activities during scheduled care coordinator appointments and regular follow-up phone calls. Patients are referred to community resources as needed. The care coordinator also contacts and assists patients in the transition from the hospital or skilled nursing facility to the home. Home visits are also made when indicated.

Care Management Tip:
Develop patient care plans as a part of the EMR so it can be printed and provided to the patient upon completion of the visit.

Health Coach versus Care Coordinator

Health Coach	Care Coordinator
• Patient-focused	• Patient-focused goal setting for high risk
• Works 1:1 with patients	• Care planning, follow-up
• Patient education and support	• Care transitions
• Preventive screening for all risk levels	• Works directly with external facilities

Upper Valley Family Care has established workflows to define both roles. Both roles spend most of their time interacting with patients so a major focus has been defining a staged approach to conversations to prevent overwhelming the patients with information. This practice emphasizes accurate, discrete EHR entries to eliminate time-wasting patient changes. Correctly entered information helps the care coordinator or health coach to access information quickly to identify relevant patient needs.

Care Management Tip:
One efficient method of avoiding patient chases is recording information in designated fields within the EHR so it can be accessed quickly by the care manager.

Upper Valley Family Care believes the care management process slows the patient visit process and increases staffing patterns. However, the provider now focuses solely on why the patient is presenting, knowing the health coach has already dealt with any outstanding health maintenance needs. Providers commented on this improvement immediately after the health coach joined the staff. Dealing with the preventive care for patients at all risk levels helps to lower the risk status of the individual so that the care coordinator need only deal with the process of care management of the high-risk individuals.

Survey data shows 100% of patients seeing the care coordination agree or moderately agree that it was a positive experience and that they received helpful information.

Upper Valley Family Care has a sister office in Piqua, Ohio, that is served by the same provider group. The team approach to care management was initiated at the Troy office, where the health coach role was initially added. CQM scores clearly demonstrate which of the two Upper Valley offices had a health coach as a part of care management initially: preventive care measures were 8 to 12 percent better for the office with the health coach. As for the care coordinator services, 100 percent of the patients seeing the care coordinator agree or moderately agree that it was a positive experience and that they received helpful information and services. They have since added a health coach to both sites, and have determined the best staffing for total care management is one health coach per two providers. For high-risk patients, there is a care coordinator at each site as well.

As Upper Valley created its care management program, the most significant barrier it encountered was identifying and dealing with varying socioeconomic and education levels in their patient population. In the process of implementing care management, it became apparent that patients weren't completely forthcoming in the office. Home visits by care coordinators revealed patients who could not read and others who were improperly taking their medications. The practice realized that determining the full perspective of the patient and then matching the patient to needed services was critical to effective care management.

Care Management Teams Working with Care Coordinators

Dennis Novak, MD, PA, Forked River, New Jersey

Independent; one physician, one PA, one ANP; 3,694 patients

The distinction between care management and care coordination is important. A care management team-based approach can be tailored to best suit the practice and its empanelled patient population. The duties of care management and care coordination can be combined into one FTE or divided among several members of the team. The care management responsibilities can be divided among the entire spectrum of providers, or in the following example, between one RN and the practice's PA and APN.

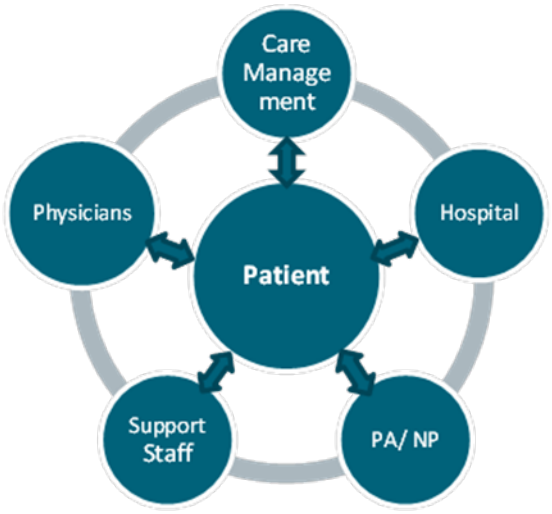


Figure 1: Care Manager Communication Flow

Dennis Novak, MD, in Forked River, New Jersey, is a one-physician practice supported by a PA and an APN. With the goal of providing the best care to its patients in a timely manner, this practice decided that the care manager role (also known as nurse care coordinator in this practice) should be filled by someone who knows their patients, practice and providers and has a good understanding of the practice mission. This practice attempted to achieve care management initially with a part-time nurse care coordinator but found that patients often returned calls when the coordinator was off. Making the nurse care coordinator a full-time position facilitated her role as a key component in the clinic's communication process. An RN who was already on staff eagerly accepted the challenge of the new role.

Practice culture and dynamics helped accelerate transformation in this office. The PA and ANP who had strong rapport with the patient panel also had personal knowledge of patient goals and needs. Understanding how care management tied into improved outcomes motivated the staff to willingly accept additional responsibilities and improve coordination with each other.

Tips for Successful Care Management:

1. Ensure constant communication between all staff.
2. Educate staff on the goals and their roles in the process.
3. Solicit staff input in process.

Providers notify the nurse care coordinator of all patients sent to or referred to other facilities. Support staff alerts the care coordinator of patient admissions. The care coordinator initiates the preliminary tracking of care transitions with the assistance of support staff. The PA and ANP then assume the care management responsibilities of the high-risk patients so that each person functions to the highest degree of their capabilities.

Dr. Novak feels the RN care coordinator is the linchpin for successful care management. This role must have the authority and skill to make decisions and the confidence that the practitioners trust her expertise and support her role. While this is not an easy job, the care coordinator has found patient response gratifying.

Like other practices, Dr. Novak has found that thorough care management may extend the overall patient visit time. Prior to the visit, the RN coordinator addresses gaps in care or preventive needs. During the provider encounter, the physician is able to solely focus on the patient's acute concerns.

The practice experienced how the nurse coordinator contributes to improved overall care during the care of a patient with a possible critical medical need. A specialist had ordered an imaging study that showed a critical condition. The specialist's office filed the report with the primary care office in preparation for a scheduled follow-up appointment. However, the specialist's office canceled the appointment due to inclement weather and failed to reschedule the patient. When the follow-up paperwork came to the nurse coordinator's attention in the primary care office, she recognized the urgency of the situation and alerted the primary care physician, who contacted the specialist. The appointment was quickly re-established, resulting in a timely and safer outcome for the patient.

Embedding Care Management into Workflow

TriHealth Physician Partners, Springdale, Ohio
System; five physicians, one ANP; 12-13,000 patients

TriHealth is a Cincinnati-based, not-for-profit health system. Nineteen of the 34 TriHealth practices are CPC practices that serve 149,420 empanelled patients. The Springdale practice providers have an average of 2,800 patients per provider. As the multi-practice system tackled the administrative and clinic logistics of integrating care management into workflow, staffing and other processes, TriHealth's care management staff pulled tenets from best practices to get started.

As physicians meet with patients, they introduce the care manager, explain their role and describe how the care manager will regularly contact them.

All practice sites follow the same care management processes, but daily work varies among the care managers in accordance with the patient's level of need. In each risk level, TriHealth has identified "universal" services that apply to all patients in that level. Those services are augmented by care coordination services that often extend outside the practice walls, across other clinical services (dietitian, for example), and into the patient's home and community. This wrap-around approach helps eliminate the gaps that often lead to ineffective self-management and other barriers to successful disease management and wellness.

As physicians meet with these patients, they introduce the care manager, explain the role in their care and describe how the care manager will regularly contact them. The physician introduction of the care manager role increases patient engagement especially for the high-risk patients who need more services.

Washington Regional Clinic for Senior Health in Fayetteville, Arkansas, consists of four geriatricians, one internist, one neurologist, three APNs and two social workers. The social workers are available to patients and their care partners to assist with their social service needs, such as finding appropriate in-home care support, making the transition to a nursing home and applying for prescription assistance. Caregivers appreciate the psycho-educational support groups and one-to-one support to help them manage their loved ones' needs. Washington Regional followed the workflow diagram below to help them visualize the care manager's role in the practice.

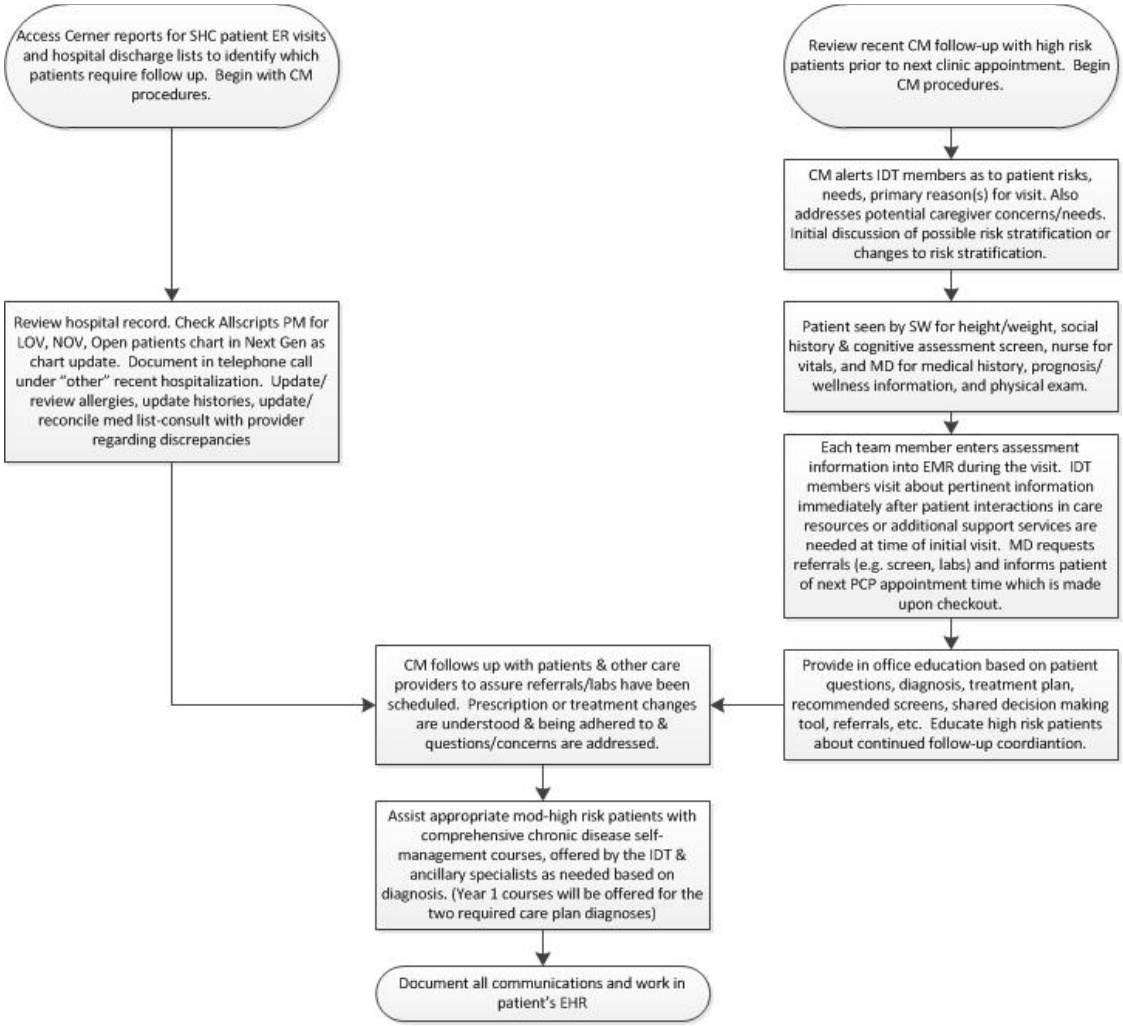


Figure 4: Washington Regional Clinic for Senior Health Workflow

Erickson Health Medical Group created a workflow diagram to describe its care management practice. The workflow begins with a quarterly risk report on all patients. This report is generated from the Centricity and ranks all patients by risk score according to their diagnosis.

The horizontal swim lanes delineate each participant in the care management work process and that person's role in the process. The workflow also connects and sequences the activities each participant performs.

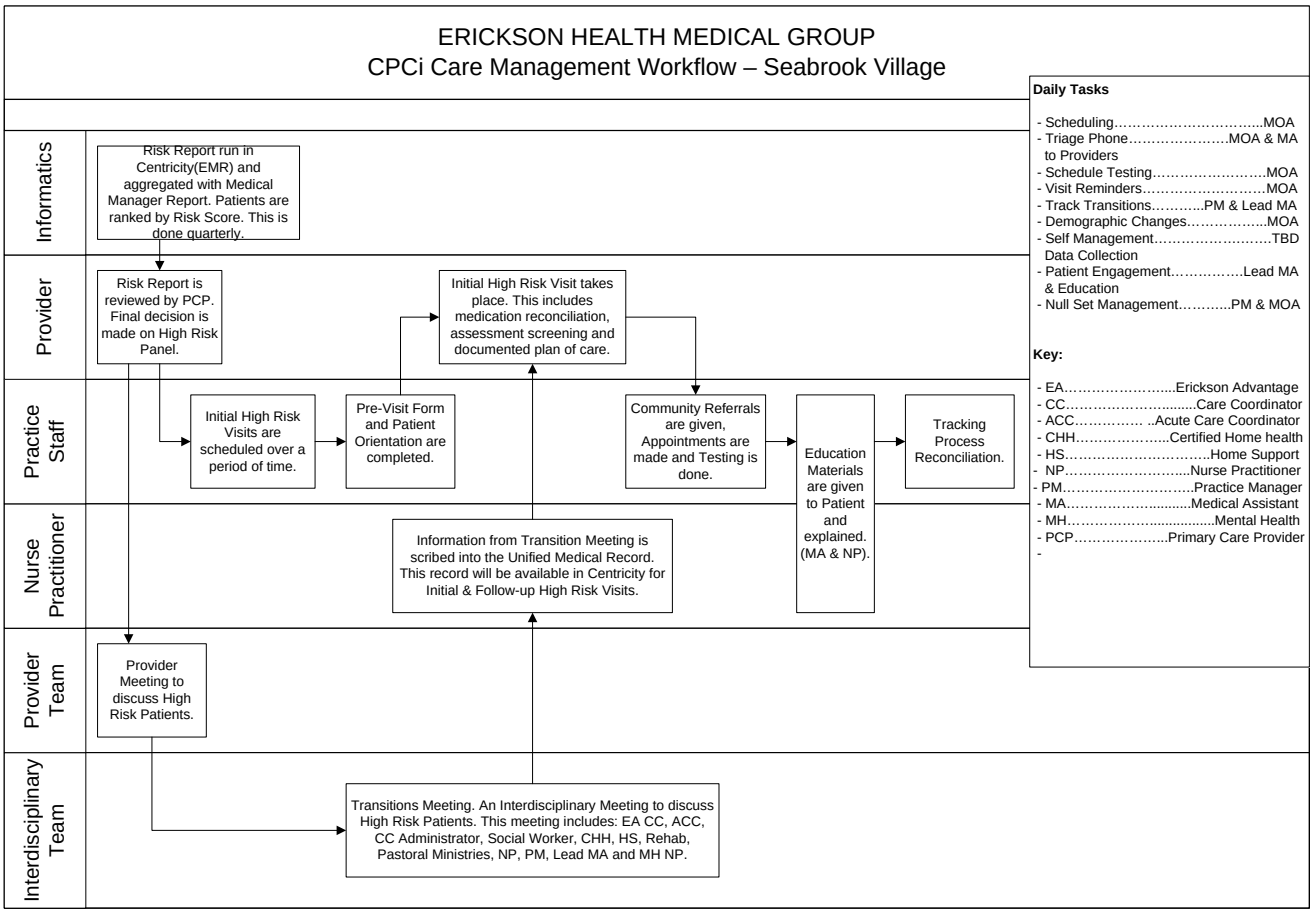


Figure 5: Erickson Health Medical Group Care Management Workflow

Conclusion

Care management is crucial for practices to achieve the aims of CPC by creating a relationship-based engagement between the patient and care team that is proactive, longitudinal and focused on improving the patient's health and meeting their health care goals. These case studies exemplify strategic options in support of CPC practices building their care management capabilities. The capabilities' larger context of care management derives from and in turn supports the key change concepts supporting the five comprehensive primary care functions:

- Access and continuity
- Planned care for chronic conditions and preventive care
- Risk-stratified care management
- Patient and care giver engagement
- Coordination of care

Since the inception of the CPC program the hire and use of care managers has increased from 980 FTEs to 2,500 care manager FTEs. Care management has many benefits for patients. As the CPC work continues, practices will develop more innovative approaches to ensure patients receive these valuable services.

Resources

Care Management

Care Management Tools

Care Management in CPC (1-page PDF)
Definition, essential features and distinction between care management and care coordination. This is a critical document for educating team members and framing how to do the work of care management.

Compilation: Care Coordinator Job Descriptions
Examples of care coordinator job descriptions.

IHI: Chronic Care Management
This web page lists several tools, articles, models and assessments available at the Institute for Healthcare Improvement Knowledge Center. The resources available include identification of six fundamental areas forming a system that encourages high-quality chronic disease management, and a survey to assess your organization's current levels of care with respect to the six components of the Chronic Care Model.

Infographic of the Transitional Care Management (TCM) Process (1-page PDF)
This workflow map summarizes a practice's transitional care management process, outlining the process following a patient's hospital discharge. Includes the documentation process and lists responsibilities by role.

Spotlight: TriHealth, Feb. 21, 2014 (3-page PDF)
This perspective on care management comes from TriHealth, a Cincinnati-based, not-for-profit health system. Four LLCs operate a total of 34 primary care offices affiliated with TriHealth; 19 of those are CPC practices that serve nearly 150,000 empanelled patients. As the multi-practice system tackled the administrative and clinic logistics of integrating care management into workflow, staffing and other processes, TriHealth's care management staff pulled tenets from best practices to get started. Communication, flexibility and peer-to-peer sharing have carried them through.

Transitional Care Management (3-page PDF)
Policy, procedures, billing requirements and resources for Transitional Care Management.

Care Management Webinars

Care Management, Oregon Learning Session, Dec. 20, 2012 (40-page PDF)
An overview of care management strategies, starting with who will provide the service and working through issues practices need to address as they operationalize.

Complex Care Management, Colorado Learning Session, March 8, 2013
This webinar describes high-risk care management, how it works and how practices can get started.

Coordinated Systems of Care, New York Learning Session, Jan. 24, 2013 (50-page PDF)
This webinar summarizes the common perspectives of coordinated care, strategies for formation of a comprehensive care team, strategy for delivery of case/care management.

An Overview of Risk Stratification and Care Management, CPC National Learning Community, Feb. 27, 2013 (59-page PDF)
Outlines the basics of risk stratification and how it underpins successful care management.

Empanelment

Empanelment Implementation Guide (5-page PDF)
This Implementation Guide explains empanelment within the context of CPC Program Year 2013 Milestones. It serves as a road map for empaneling patients in your practice.

Appendix

Job Descriptions

Care Manager, RN **Summit Medical Center, Colorado Springs, Colorado**

The incumbent reports directly to the Office Manager at Summit Medical Clinic (SMC). The incumbent works collaboratively with clinic staff and management within SMC to achieve objectives of the patient-centered medical home, promote patient engagement and satisfaction, improve quality outcomes and maximize the use of available resources. The incumbent has contact with patients, physicians, allied health professionals, community groups, third party payers, agencies, vendors and other health care organizations.

PRINCIPLE ACCOUNTABILITIES:
The principal purpose of this position is to coordinate the activities within an interdisciplinary care team that takes collective responsibility for proactively supporting patients' unity of body, mind and spirit.

Develops, assesses and implements a comprehensive individualized care plan to patients.

- Completes comprehensive, age appropriate assessments based on patient's individual strengths, goals and needs. Includes assessment of both acute and chronic health conditions, social environments and psychosocial determinants of health
- In consultation with the patient, physicians and other care team members, coordinator develops proactive care plan to provide unity of body, mind and spirit
- Proactive outreach to patients between primary care visits
- Conducts ongoing assessments to determine response to care plan or services. Reprioritizes care plan based on new information and updates patient care plan accordingly. Assures patient, family and care team members who participate are informed of updated plan on regular basis
- Serves as primary advocate and liaison between patient, family, provider and other care team members
- Manages care coordinators. Responsibilities include but are not limited to: delegation of administrative work, assigning duties, serving as primary point of contact and ensuring high quality care coordination

QUALIFICATIONS:
Education/Experience

- Medical Assistant or Registered Nurse Degree required
- Experience in working in public health, social work and community nursing would be a plus
- 2 years' experience working in clinical and/or community health nursing position is preferred

Knowledge/Skills/Abilities
Knowledge of community health concepts, principals of community health and ambulatory clinical nursing care, case management, care coordination and epidemiology. Skills in health assessments, interviewing techniques, teaching, communication and nursing practice. Ability to function independently, prioritize and organize work, solve problems, adapt to change, function as a team member and relate to the public.

Care Coordinator **Summit Medical Center, Colorado Springs, Colorado**

PRINCIPLE RESPONSIBILITIES:

- Assists care manager in running reports that support care management services
- Responsible for tracking referrals and tests for completion, attaching documentation to chart and tasking provider for review
- Call non-high-risk patients following ED discharge, and schedule for follow-up visit as needed within 7 days
- Call non-high-risk patients following hospital discharge and schedule follow-up appointment within 7-14 days based on acuity
- Proactive population management, running reports for gaps in care (preventative screenings, overdue labs and tests)
- Performs and directs patient care services including, but not limited to, admission interview, assessment, accurate documentation and timely patient flow
- Ensures patient is appropriately prepared for provider encounter. Prepares and obtains patient medical records and other information/documentation pertinent to patient encounter
- Screens patients to ensure priority is provided to patients in an emergency/acute situation
- Fills in for absent MAs as needed (see MA job description)

QUALIFICATIONS:

Experience:

Preferred: Two or more years ancillary health care experience in an ambulatory health care setting.

Education and/or Licensure/Certification: Must meet one of the following criteria:

- CMA: requires active certification as a Certified Medical Assistant by AAMA or a National Certified Medical Assistant (NCMA) through the National Center for Competency Testing
- RMA: requires active registration as a Registered Medical Assistant by AMT
- MA: requires completion of an accredited Medical Assistant program CMA Certification required within 24 months of hire date

BLS or BLS instructor certification is required upon hire. Acceptable credentialing bodies and certifications include the following: American Red Cross: CPR/AED for the Professional Rescuer; American Safety and Health Institute: CPR, PRO, must say "Professional Level with AED;" and American Heart Association: Basic Life Support for Healthcare Providers.

Knowledge/Skill/Abilities:

- personal management skills and tools
- organizational policies, regulations and procedures
- medical equipment and instruments
- risk management, quality improvement and infection control
- ICD-9 and CPT coding skills
- insurance protocols

Skills as demonstrated through:

- applying and modifying the principles, methods and techniques related to ancillary health care services
- continuous accurate verbal and written communication
- establishing and maintaining cooperative and collaborative working relationships with patients, medical staff and the public
- continuous time, resource and task management

Health Coach **Upper Valley Family Care, Troy, Ohio**

General Summary of Duties: Works as a team member with physicians/NPPs, care managers and floor nurses to provide quality health care. Assists physicians by helping patients gain knowledge, skills, tools and confidence to become active participants in their own care so they can reach their self-identified health goals. Identify overdue health maintenance items based on national guidelines by reviewing patient charts, reports and other tools available. Discusses national guidelines and UVFC protocols with patients.

This position is considered a Team Leader position. Nurse filling this position must also be able to work the floor as a team nurse and remain current on UVFC policies and procedures. This position is included in the Saturday nursing rotation**.**

Reports To: Nursing Supervisor

5 Principle Roles of a Health Coach:

1. **Provide Self-management Support**. Train patients in seven domains of self-management support; providing information, teaching disease-specific skills, promoting healthy behaviors, imparting problem-solving skills, assisting with the emotional impact of chronic illness, providing regular follow-up and encouraging patients to be active in their care.
2. **Bridge The Gap between Provider and Patient.** Throughout the care process, there are plenty of opportunities for disconnects between the provider and the patient. Health Coach bridges these gaps by following up with patients, asking about needs and obstacles and addressing cultural issues and social class barriers. Health Coach serves as the patient's liaison and ensures the patient understands and agrees with the plan of care.
3. **Help Patients Navigate the Health Care System.** Connect the patient with resources. Navigate patients, particularly the elderly or disabled to locate and engage in services.
4. **Offer Emotional Support.** Coping with illness is emotionally challenging. Health Coach offers emotional support to help patients cope with their illness. Health Coach must exhibit compassion, patience and be able to teach coping skills.
5. **Serve as a Continuity Manager.** Health Coach connects with patients not only at office visits but also between visits, creating familiarity and continuity. Health Coach is available and establishes a trust with their patients. Health Coach is particularly helpful where providers work part-time or see one another's patients. Health Coach is the "linking of care" provided by different providers.

Examples of Duties: This list is intended to describe the general nature and level of work performed. They include the responsibilities listed in the job description of a Medical Assistant, **in addition** to the responsibilities listed below. It is not intended to serve as an exhaustive list of all duties, skills and responsibilities required of personnel.

Health Maintenance Responsibilities

Using available reporting from CINA, i21, the EMR and other possible sources, review patient charts based on established standards of care for health maintenance needs.

- Disease management – regular checks, lab levels, other testing
- Medication management – regular checks, lab levels, other testing
- Preventive care needs – pelvic exams, mammograms, PSA, etc.

1. Discus needs with the patient.
2. Educate patients about their care and the importance of meeting their goals and assists with goal setting and plans for behavior change.
3. Make referrals as ordered by providers or by protocol.

4. Proactively contact patients to arrange follow-up on outcome goals that CINA Report shows are not being met.
5. Assist with obtaining test results from hospitals, specialists or out of area facilities if not readily available in patient's EMR.
6. Participate effectively as a team member in the clinic being accountable and helpful to co-workers, providers and patients.
7. Update patient history and health maintenance.
8. Re-index scanned documents when needed.
9. Review and clean up diagnosis lists.
10. May assist with EMR development/customization.
11. Attend scheduled and periodic meetings, trainings and other job-specific events as required.
12. Act as a "Champion" and serve as a role model to staff nurses.
13. Participate in staff/physician "huddles" and maintain "huddles."
14. Perform additional duties as assigned.

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Performance Requirements

Knowledge, Skills & Abilities:
Knowledge of grammar, spelling and punctuation. Current knowledge of medical terminology. Current knowledge of medical practice and care to assist in giving patient care over the telephone. Skill in maintaining records, including charting and recording medications. Skill in establishing and maintaining effective working relationships with patients, medical staff and the public. Ability to react calmly and effectively in emergency situations. Ability to communicate clearly. Ability to read, understand and follow oral and written instructions. Ability to make mathematical computations. Ability to see and act on priorities. Strong interpersonal skills and ability to work collaboratively with patients, non-clinical staff and clinical staff. Skill in motivational interviewing.

Education: High school diploma or GED. Graduation from an accredited school for nursing, RN or LPN or RMA/CMA.

Experience: Over one year medical office experience required.

Certificate/License: Current nursing license (RN, LPN, RMA, CMA) from the state of Ohio.

Physical Requirements: Work requires standing and walking and carrying tablet computer for long periods of time. May require stooping, bending and stretching for supplies. Occasionally lifting supplies weighing up to 30 pounds. Requires manual and finger dexterity sufficient to operate a keyboard, telephone, copier and such other office equipment as necessary. Sight and dexterity to operate a PC, copy machine, fax machine, telephone and medical equipment. Hearing must be in the normal range for patient and telephone contacts.

Health and Social Requirements:
Self-Confidence – Can diplomatically express views that may be unpopular
Self-Control – Composed, positive and focused under pressure
Conscientious – Organized and always meets deadlines/commitments
Innovation – Open to new ideas, approaches and information
Achievement Drive – Consistently strives to improve standards of excellence
Commitment – Makes sacrifices to meet goals and believes in core values

Initiative – Pursues goals beyond what is expected of them
Understanding – Senses others' feelings/perspectives and takes interest in them
Influence – Can effectively persuade others
Communication – Deals with issues, listens and seeks mutual understanding
Conflict-Management – Diplomatic, tactful and able to calm tense situations
Collaboration and Cooperation – Shares plans, information and resources
Optimism – Persistent despite obstacles and expects success, not failure

Working Requirements: Work is performed in the office environment. Involves contact with the staff and patients. Work may be repetitious at times. Interactions with others can be interruptive. Requires exposure to communicable diseases or body fluids, with frequent exposure to toxic substances, medicinal preparations and other conditions common to a medical environment. Work can be stressful and fast-paced. Interaction with others is constant and interruptive

Nurse Care Coordinator **Upper Valley Family Care, Troy, Ohio**

General Summary of Duties: Provides care coordination for Upper Valley Family Care patients and support our Patient-Centered Medical Home. This includes developing and monitoring care coordination processes and supporting primary clinical teams with these efforts. It also includes identifying the high-acuity patient population and working to ensure care coordination for this patient population. The Nurse Care Coordinator is responsible for implementing specific care planning activities as well as referring to available community resources. Care Coordinator also assists patients in the transition from the hospital or SNF to home. Also includes evaluating the patient in the home when appropriate. The position may involve some patient triage.

The Nurse Care Coordinator will lead a Care Coordination Team which consists of the Care Coordination Manager, Providers, Clinical and Business staff and Practice Manager to best serve the needs of the patient.

The Nurse Care Coordinator will be responsible for appropriate documentation, report running, analysis and report development.

Reports To: Physicians and management team of Upper Valley Family Care and Care Coordination Manager of HPC

Direct Supervision of: None

Team Supervision of: None

Typical Physical Demands: Requires full range of body motion including stooping, bending, stretching and lifting, manual and finger dexterity and hand-eye coordination. Requires standing and walking for extended periods of time. Requires carrying and operating a notebook and or tablet computer. Occasionally lifts or carries items weighing up to 50 lbs. Requires corrected vision and hearing to normal range to record, prepare and communicate with patients and complete appropriate reports. Requires sight and dexterity to operate office equipment. Requires dexterity and typing skills to operate and document in an electronic environment. May require working under stressful conditions or working late or irregular hours. Requires travel to patient homes.

Typical Working Demands: Requires high level of tolerance in telephone situations. Remains calm during stressful periods and act appropriately. Establishes and maintains a tactful and strong level of interpersonal skills and the ability to work collaboratively with patients, non-clinical staff, clinical staff workers and the

public. Must be able to quickly learn new skills and concepts and adapt to change. Must have strong skills in independent problem solving and process management. Must be a self-starter, self-directed and must be able to implement new programs. Must be highly organized and detail oriented. Accepts responsibility and follows through on projects and activities. Must have the ability to analyze and present data accurately and effectively. Attends and participates in mandatory facility wide and department training/meetings as required.

Typical Working Hours: Work hours are varied Monday through Friday. Must be able to work early and/or evening hours. Must be able to travel between offices and to patient homes as necessary.

Example of Duties: This list is not intended to serve as an exhaustive list of all duties, skills and responsibilities required.

Works with all teams as a resource on care management of Upper Valley Family Care patients. This includes:

1. Planning pre-visit workflow to ensure care completion prior to visit whenever possible.
2. Coordinating care with hospitals, ER, SNF, consulting physicians and community resources.
3. Developing a workflow to ensure smooth transition of care for patients treated in a facility (inpatient or emergency department), by a specialty physician or by another health care provider.
4. Providing after-visit summary review with patients whenever appropriate.
5. Involving the patients in activities to improve their health (patient engagement)
6. Educating the patient about self-management tasks they can undertake to gain greater control of their health status

Actively manage assigned panel of chronic care patients (high acuity, risks levels 4, 5, 6). This includes:

1. Perform initial patient assessment and develop individual patient care plan.
2. Ensure the care plan is followed.
3. Develop relationships with the patients as an integral team member.
4. Provide follow-up contact with patients as indicated to ensure compliance with recommendations, medications, lab/x-ray, specialist visits, PCP visits, dieticians etc.
5. Manage many aspects of patient care as needed. This includes referrals to specialists, hospitalizations, ER visit, ancillary testing and other enabling services.
6. Provide telephone advice, handling urgent calls and emergent calls.
7. Anticipate the needs for this patient population, see that the necessary documentation and pre-visit planning is completed or requested before the patient visit. Work patients and their care teams to coordinate change, readiness, needs, assessment and develop an individualized treatment care plan.
8. Assist patients in setting *SMART* goals for self-management, teaching them how to do self-management tasks and reporting abnormal findings to their physician.
9. Collaborate with patients, physicians and other care team members in assessing patient progress toward individual health care goals.
10. Assess barriers when patients are not meeting treatment goals, not following treatment care plan or have not kept important appointments.
11. Collaborate with payer case managers for additional services when appropriate.
12. Help develop and maintain a list of medical supply and community resources available to patients.
13. Assist in developing protocols for PCMH delivery model and reporting outcomes.
14. Appropriately utilize EMR to ensure consistent documentation of services and use of searchable and reportable fields for activity tracking and measurement of change/outcomes.

Performance Requirements:

Knowledge, Skills and Abilities:
Knowledge of grammar, spelling and punctuation. Current knowledge of medical terminology. Current knowledge of medical practice and care to assist in giving patient care over the telephone. Skill in maintaining electronic medical record including charting and recording medications. Skill in establishing and maintaining effective working relationships with patients, medical staff and the public. Ability to react calmly and effectively in emergency situations. Ability to communicate clearly. Ability to read, understand and follow oral and written instructions. Ability to make mathematical computations. Ability to see priorities. Ability to analyze and present data accurately and effectively. Strong skills in independent problem solving and process management. Strong interpersonal skills and ability to work collaboratively with patients, non-clinical staff, clinical staff and project teams. Effective oral and written skills to document and communicate information correctly. Ability to communicate with tact and diplomacy.

Education: RN (BSN preferred) from accredited school of nursing required.

Experience: At least 3 years clinical experience in acute and outpatient settings, homecare and/or physician offices. Previous experience with clinical pathways, data analysis and health care operations preferred.

Computer Experience: Previous experience with electronic medical records preferred. Proficiency in use of Windows, Word, Excel, database entry and the internet preferred.

Licenses: Current Ohio RN License and CPR certification. Current unrestricted Ohio driver's license.

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Clinical Workflows

Summit Medical Clinical Care Coordination Job Flow

Goal: To capture high-risk patients during each visit within the clinic

Purpose: To allow the clinic to recognize who the high-risk patients are, so that the care of the patient is approached in a meaningful and purposeful manner.

Recognizing and caring for the high-risk patient:

1. Develop office protocols that will be congruent between all providers and staff members for determining the proper approach to the care of the high-risk patient population such as patient empanelment, risk stratification and the care management templates.
2. Care coordinator will print and review the daily schedule for all providers and identify the high-risk patients.
3. Each provider and their medical assistant will be notified of their high-risk patients for the day.
4. Care coordination will review each chart before the patients are seen by the physician to determine that their routine maintenance is up to date.
5. If the patient is missing any routine procedures or necessary referral to community specialists, per disease protocol, the care coordinator will order, notify the patient and follow-up to ensure they are completed.
6. To ensure that the patient is aware that the care coordinator is an additional point-of-contact for them, during the office visit the care coordinator will be introduced to the patient.

Village Primary Care, Hoosick, NY
Transitional Care Nurse Job Flow

Description: Workflow for integration with Transitional Care Nurse (TCN) for patients who are discharged from Southwest Vermont Medical Center (SVMC)

1. Identify inpatient for TCN (PCP listed as Carroll, Romac or Rowe).
2. TCN reviews hospital chart and Village Primary Care chart and meets with inpatient (if inpatient meets TCN criteria proceed to step 3).
3. A. Inpatient interested in TCN services (proceed to step 4) or B. Inpatient not interested in TCN services (stop and note in chart).
4. Secure inpatient consent (if consent is obtained proceed to step 5).
5. TCN follows and meets with inpatient and family, completes needs assessment, screening and discharge plan.
6. Patient discharged to home or other facility.
7. TCN does home visit or other facility visit within three days.
8. TCN assists in scheduling patient follow-up visit with PCP and attends visit with patient.
9. TCN continues to follow patient post discharge working with PCP to ensure discharge plan is followed and updated as necessary.

Risk Stratification Tools

Grand Lake Primary Care Risk Stratification Tool

This three-strata risk stratification tool may work well for smaller practices or those that do not have the ability to integrate a risk stratification tool within the EHR.

Risk Stratification Protocol for Staff

LOW	MEDIUM	HIGH
No problems. Minimal problems.	Controlled: HTN, Hyperlipidemia. Diabetes A1c less than 7 Allergies Asthma Low ER or Hospital utilizer. Psychiatric Issues Cancers in remission.	CHF COPD DIABETES: A1c greater than 7 CANCER DEMENTIA High ER/Hospital Utilizer Poor social support HIGH MORTALITY RISK
Preventive Care	Preventive Care	Preventive Care
	Medication Compliance Checks	Medication Compliance Checks
	Specialty Referrals if needed	Specialty Referrals if Needed
	Home Management Education	Home Health? Or Hospice?
	Diabetes Ed Classes	Weekly Phone calls/Monthly visits
		Home Management Education Family/caregiver Engagement. Home Visits?

Adopted Renee J Russell, MD, INC, PC 1/23/2013

Medical Assistants:

Every Patient seen for office visit that day is risk stratified and care plan is developed. Remind Providers that you have done it. Remind Providers to double check your work or help with development. MA's can make a referral to Home Health.

Care Manager:

Every patient that comes out of ER or hospital: risk stratify and develop care plan while setting up follow up and referrals.

RISK STRATIFICATION: for entry into soapware type the following:

Riskcat(space)

Carex(space)

Village Primary Care Risk Stratification Tool

This five-strata risk stratification tool will help show a greater distribution within the practice's patient population.

Patient Name: _____ **Age:** _____

Medical Record Number: _____ **Date of Risk Assessment:** _____

Does patient present with these conditions?

PRESENT		CHRONIC	PRESENT		CHRONIC
☐	Allergy, asthma	☐	☐	Malignancies	☐
☐	Cardiovascular	☐	☐	Mental health/psychosocial	☐
☐	Ear, nose, mouth and throat	☐	☐	Musculoskeletal	☐
☐	Endocrine	☐	☐	Neurologic	☐
☐	Eye	☐	☐	Nutrition	☐
☐	Female Reproductive	☐	☐	Renal	☐
☐	Gastrointestinal/hepatic	☐	☐	Respiratory	☐
☐	Genetic	☐	☐	Rheumatologic	☐
☐	Genito-Urinary	☐	☐	Skin	☐
☐	Hematologic	☐	☐	Toxic effects	☐
☐	Infections	☐			

Count as chronic:

- ☐ The patient of caregiver of a dependent patient has a serious and persistent mental illness
- ☐ Hospitalization during last 12 months
- ☐ More than two emergency room visits in last 12 months

Chronic Condition Count:	
Initial assigned risk tier:	

Chronic Count	Tier
0	1
1-3	2
4-6	3
7-9	4
10 or more	5

St. Bernards Clopton Clinic Risk Stratification Tool

This four-strata risk stratification tool adds points to account for mental health conditions.

Utilization	Points	Yes/No
One hospitalization in the last 12 months	2	
Two hospitalizations or ED visits in the last 12 months	5	
Three or more hospitalizations in the last 12 months	10	
Age	**Points**	**Yes/No**
60-69 years of age	1	
70-79 years of age	2	
80 and older	3	
Health Conditions	**Points**	**Yes/No**
AIDS (not just HIV positive)	6	
Asthma	1	
Atrial Fibrillation	1	
CAD	1	
Cancer, Active (Current therapy-Place as High Risk)	13	
Cancer, Remission (Mod. risk if in remission but continues to have related problems or still under Onc./Rad.Onc care)	7	
Cancer, Hx of (Low Risk if in remission and no problems)	1	
CHF	1	
Chronic Pain	2	
CKD, Stage 3 or 4 or on Dialysis (moderate to severe)	5	
COPD	2	
CVA	1	
Dementia/Alzheimer's Disease/Parkinson's Disease	2	
DM, Controlled	3	
DM, Complicated/Uncontrolled	6	
Hemiplegia	1	
HTN	1	
Hyperlipidemia/Hypercholesterolemia	1	
Hypothyroidism	1	
Liver Disease	2	
MI	2	
Obesity	2	
Paraplegia	2	
Polypharmacy (6 or more routine medications)	4	
Peripheral Vascular Disease	1	
Mental Health	**Points**	**Yes/No**
Anxiety	2	
Depression	2	
Mental Retardation	1	
Behavioral	**Points**	**Yes/No**
Current Smoker	2	
Non-compliance (Ex. 2 or more "No Show" appts./year or Ex. DM/CHF/HTN pts that have not been seen in past 6 mos)	4	
Substance Abuse	3	

Low Risk 0-6
Mod Risk 7-12
Mod-High Risk 13-15
High Risk >16

Score:

Mercy Adult Risk Stratification Tool

Mercy Adult Risk Stratification Tool							**19 YEARS AND OLDER**
Risk Level:		Evaluated by:		Evaluation Date:		Last Evaluation Date:	
Patient Name:				Provider:		Last Risk Level:	
Age:		DOB:					
Risk Stratification Level: Score		**Risk 1:** 0-1	**Risk 2:** 2-3	**Risk 3:** 4-6	**Risk 4:** 7-9	**Risk 5:** 10-13	**Risk 6:** 14-18
CARE PLANNING		**LOW**		**MODERATE**		**HIGH**	**EXTREMELY HIGH**	**SCORE**
SCORE		**0**		**1**		**2**	
1	**AGE**	19 years - 64 years		65 years to 79 years		80 years or older	
2	**HOSPITALIZATIONS** (last 12 months)	0 TO 1		2		3 OR MORE	
3	**ER VISITS** (last 12 months)	0 TO 1		2		3 OR MORE	
4	**ALL OFFICE VISITS** (last 12 months) *exclude OB visits*	1 to 2		3 to 6		7 OR MORE	
5	**CURRENT PRESCRIPTION MEDICATIONS** (including oxygen)	0-2 medications		3-5 medications		6 or MORE	
6	**LANGUAGE/HEALTH LITERACY**	▪ Primary language: English ▪ Carries out plan of care well ▪ Demonstrates understating of health care needs ▪ Independently seeks health information		▪ Limited English: verbal skills ▪ Hearing impaired ▪ Carries out some of the plan of care ▪ Requires some reinforcement		▪ Requires interpreter for all practice interactions ▪ Not able to carry out plan of care without continued reinforcement ▪ Requires routine reinforcement and education	
7	**CHRONIC DISEASE** (does not include mental health dx)	▪ No chronic disease ▪ AT RISK: pre-diabetes, borderline hypertension •Non Smoker •BMI 18.5 - 25		• 1-3 chronic diseases diagnoses • 1 - 15 years tobacco use history • BMI < 18.5 - > 25		▪ 4 or more chronic disease diagnoses •15 years plus tobacco use history • BMI > 35	
8	**CHRONIC DISEASE QUALIFIER**	▪ N/A		▪ 1 or more chronic disease diagnoses uncontrolled		▪ 1 or more chronic disease diagnoses, severely uncontrolled	
9	**MENTAL & BEHAVIORAL HEALTH** (includes but not limited to dementias, substance abuse, autistic disorders, eating disorders, developmental delays)	▪ No Mental Health diagnoses ▪ Long-term stability demonstrated with medication		▪ 1-2 Mental health diagnoses ▪ Routine follow up with provider and or mental health provider ▪ 1-2 Significant life stressors (Divorce, Death, Job Loss, Moving, etc.)		▪ 3 or more mental health diagnoses ▪ 3 or more significant life stressors (Divorce, Death, Job Loss, Moving, etc.)	
10	**MENTAL & BEHAVIORAL HEALTH QUALIFIER**	▪ N/A		▪ 1 or more Mental Health diagnoses uncontrolled		▪ 1 or more Mental Health diagnoses severely uncontrolled	
11	**SOCIAL DETERMINIATION & SELF-MANAGEMENT**	▪ Steady income ▪ Independent ▪ Stable residency ▪ Family or other support ▪ Adequate medical insurance		▪ Receives some support to meet social needs ▪ Some medical insurance ▪ Lives alone needs some assistance with ADLs		▪ Lives in a Nursing Home or Assisted Living ▪ Hospice ▪ Homebound ▪ Homeless ▪ Unsafe home environment ▪ Unemployed ▪ Lack of financial or family support that impacts care ▪ Transportation barrier ▪ No medical insurance	
Comments:							
Complex Care Coordinator Referral (Please circle)				YES	NO		

Mercy Pediatric Risk Stratification Tool

Mercy Pediatric Risk Stratification Tool							BIRTH TO 18 YEARS
Risk Level:		Evaluated by:		Evaluation Date:		Last Evaluation Date:	
Patient Name:				Provider:		Last Risk Level:	
Age:		DOB:					
Risk Stratification Level: Score		**Risk 1:** 0-1	**Risk 2:** 2-3	**Risk 3:** 4-6	**Risk 4:** 7-9	**Risk 5:** 10-13	**Risk 6:** 14-18
CARE PLANNING		**LOW**		**MODERATE**		**HIGH**	**EXTREMELY HIGH**	**SCORE**
SCORE		**0**		**1**		**2**	
1	**AGE**	3 years to 18 years		Birth to 35 months		Premature (<36wks) - 12 months	
2	**HOSPITALIZATIONS** (last 12 months)	0 TO 1		2		3 OR MORE	
3	**ER VISITS** (last 12 months)	0 TO 1		2		3 OR MORE	
4	**ALL OFFICE VISITS** (last 12 months)	Birth to 23 months: 4-5 visits 2 years to 18 years: 1-2 visits		Birth to 23 months: 2-3 or 6-7 visits 2 years to 18 years: 3-4 visits		Birth to 23 months: 1 visit or >8 visits 2 years to 18 years: >5 visits	
5	**CURRENT PRESCRIPTION MEDICATIONS**	No Medications		1-2 medications		3 or MORE Oxygen Use	
6	**Family/Caregiver LANGUAGE/HEALTH LITERACY**	▪ Primary language: English ▪ Carry's out plan of care well ▪ Demonstrates understating of health care needs ▪ Independently seeks health information		▪ Limited English: verbal skills ▪ Hearing impaired ▪ Carries out some of the plan of care ▪ Requires some reinforcement		▪ Requires interpreter for all practice interactions ▪ Not able to carry out plan of care without continued reinforcement ▪ Requires routine reinforcement and education	
7	**CHRONIC DISEASE** (does not include mental health dx)	▪ No chronic disease • Non Smoker/no secondhand smoke • Growth chart: Between the 25th and 75th percentile		• 1 chronic diseases diagnosis • Exposure to secondhand smoke • Growth Chart: <25th percentile or >75th percentile		▪ 2 or more chronic disease diagnoses • Tobacco use • Growth chart: <10th percentile or >95th percentile	
8	**CHRONIC DISEASE QUALIFIER**	▪ N/A		▪ 1 or more chronic disease diagnoses uncontrolled		▪ 1 or more chronic disease diagnoses, severely uncontrolled	
9	**Family/Caregiver/Patient MENTAL & BEHAVIORAL HEALTH** (includes but not limited to dementias, substance abuse, autistic disorders, eating disorders, developmental delays, depression, ADD, ADHD, etc.)	▪ No Mental Health diagnoses		▪ 1 Mental health diagnoses ▪ Routine follow up with provider and or mental health provider ▪ 1-2 Significant life stressors (divorced parents, young parents <20, single parent, unemployment)		▪ 2 or more mental health diagnoses ▪ 3 or more significant life stressors (divorced parents, young parents <20, single parent, unemployment)	
10	**MENTAL & BEHAVIORAL HEALTH QUALIFIER**	▪ N/A		▪ 1 or more Mental Health diagnoses uncontrolled		▪ 1 or more Mental Health diagnoses severely uncontrolled	
11	**Family/Caregiver/Patient SOCIAL DETERMINIATION & SELF-MANAGEMENT**	▪ Steady income ▪ Stable residence ▪ Adequate medical insurance Meets basic ADL's		▪ Receives some support to meet social needs ▪ Some medical insurance ▪ Meets some of basic ADLs		▪ Homeless ▪ Unsafe home environment ▪ Unemployed ▪ Lack of financial or family support that impacts care ▪ Transportation barrier ▪ No medical insurance ▪ Foster care	
Comments:							
Complex Care Coordinator Referral (Please circle)				YES	NO		

References

Randall S. Brown, Deborah Peikes, Greg Peterson, Jennifer Schore and Carol M. Razafindrakoto. Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients. *Health Affairs*, 31, no.6 (2012):1156-1166

Haas, Lindsey R. Assessment of Risk Stratification Methods: Identifying Patients for Care Coordination within a Medical Home. Presented at Academy Health Conference June 26, 2012

AAFP Risk-Stratified Care Management
This web page explains what risk-stratified care management is, in that it begins with a periodic and systematic assessment of each patient's health risk status, using criteria from multiple sources to develop a personalized care plan.

AAFP Risk-Stratified Care Management and Coordination Table (1-page PDF)
This table shows examples of potentially significant risk factors, as well as risk categories and levels. It provides guidance to identifying disease burden and determining health risk status.

Advancing Integrated Mental Health Solutions (AIMS)
The AIMS Center, housed within the University of Washington's Division of Integrated Care & Public Health, Department of Psychiatry and Behavioral Sciences, seeks to improve the health and mental health of populations through patient-centered, integrated mental health services for individuals across the age span. The site provides information on integrated mental health care including principles and tasks for integrating care.

Assessment of Risk Stratification Methods Identifying Patients for Care Coordination within a Medical Home (27-page PDF)
This Mayo Clinic presentation at the Academy Health Conference in June 2012 focuses on identifying patients with care coordination needs are part of a Medical Home.

Care Management in CPC: Definition
Care management is a tailored primary care function. In CPC, specific dynamics of the initiative will shape how and when your practice initiates this care. The definition provided on the Collaboration site describes how care management supports the drivers for comprehensive primary care.

Care Management of High Risk Patients by WR Clinic for Senior Health
This resource is provided by Washington Regional Clinic for Senior Health as their approach to Milestone 2: Care Management of High-Risk Patients. Attached is a description of their approach, their care management workflow and definitions of their risk.

CPC Practice Spotlight – SAMA Healthcare, Dec. 6, 2013 (2-page PDF)
SAMA Healthcare Services in Arkansas describes the practice's approach to risk stratification.

NIHCR High Intensity Primary Care
The National Institute for Health Care Reform offers this article outlining approaches and models for "high-intensity primary care," which could prevent costly emergency department visits and hospitalizations. High-

intensity primary care could be offered to a handful of patients with complex or multiple chronic conditions, such as diabetes, congestive heart failure, obesity and depression.

An Overview of Risk Stratification and Care Management, CPC National Learning Community, Feb. 27, 2013 (59-page PDF)
Outlines the basics of risk stratification and how to underpins successful care management.

PCPCC: Successful Examples of Integrated Models
The Patient-Centered Primary Care Collaborative presents successful examples of integrated models of care in primary care from around the world, including links to project websites.

Project BOOST Team. The Society of Hospital Medicine Care Transitions Implementation Guide: Project BOOST: **B**etter **O**utcomes by **O**ptimizing **S**afe **T**ransitions. Society of Hospital Medicine website, Care Transitions Quality Improvement Resource Room http://www.hospitalmedicine.org. Accessed Aug. 1, 2012.

Risk Stratification Process (2-page PDF)
Risk stratification method using four levels, which correspond to primary, secondary and tertiary prevention as levels 1, 2 and 3. The 4th level is the patient who is a vastly complicated and high-risk individual.

Risk Stratification Webinars
Care Plans, New Jersey Learning Session, Nov. 6, 2013 (17-page PDF)
Learn to design workflows with a focus on care plans; navigate workflow issues within the process.

Risk Stratification, National webinar, April 9, 2014 (38-page PDF)
This presentation describes progress to date from CPC practices as well as showcases success stories from the field. Discussion includes work flow considerations, care management strategies and measures of success.

Risk Stratification, Ohio Learning Session, Jan. 22, 2013 (40-page PDF)
A review of risk stratification, a care management overview and practice stories.

Risk Stratified Care Management, AR/OK Learning Session, Dec. 21, 2012
This presentation provides steps toward starting a risk stratification care management plan as well as what to avoid. Comprehensive notes for this session are provided here as well.