

Table 1: Example of Potentially Significant Risk Factors to be Considered when Assigning Risk Levels

Clinical Diagnoses, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization	Clinician Input (Personal Knowledge)
<ul style="list-style-type: none"> Any chronic disease, particularly that is not at desired goal Multiple co-morbidities Chronic pain Substance abuse Behavioral health diagnosis Terminal illness Advanced age with frailty Pre-term delivery of newborn Patients with special needs Dental health Dementia/Alzheimer's Disease 	<ul style="list-style-type: none"> Non-ambulatory Needs Assistance with Activities of Daily Living (ADLs) Severely diminished functional status Declining eyesight Extreme weakness or fatigue At risk for falls 	<ul style="list-style-type: none"> Lack of financial support Lack of family support that impacts care Unemployed Homelessness No health insurance Low health literacy Unsafe home environment Lack of transportation Language barriers Lives alone 	<ul style="list-style-type: none"> Frequent hospitalizations Frequent ER or urgent care visits Multiple providers Hospital readmission within 30 days Major procedure in last year Chronic kidney disease Brain trauma Expensive medications 	<ul style="list-style-type: none"> Polypharmacy High-risk medications Difficulty following treatment plan Difficulty taking medications as prescribed Recent visit to a long-term facility or other transition of care Spouse recently deceased Low confidence or ability for self-management Answer the question: Is this patient likely to be hospitalized in the next 30 days?

Table 2: Identifying Disease Burden, Determining Health Risk Status, and General Care Plan Considerations

Level 1 PRIMARY PREVENTION	Level 2 PRIMARY PREVENTION	Level 3 SECONDARY PREVENTION	Level 4 SECONDARY PREVENTION	Level 5 TERTIARY PREVENTION	Level 6 CATASTROPHIC CARE
<p>Is the patient healthy, with no significant risk factors?</p> <p>GOAL: To prevent onset of disease (Low Resource Use)</p>	<p>Is the patient healthy, but at risk for a chronic disease, or has other significant risk factors?</p> <p>GOAL: To prevent onset of disease (Low Resource Use)</p>	<p>Does the patient have one or more chronic diseases, with significant risk factors, but is stable or at desired treatment goals?</p> <p>GOAL: To treat a disease, reduce rising risk, and avoid serious complications (Moderate Resource Use)</p>	<p>Does the patient have one or more chronic diseases, with significant risk factors, and is unstable or not at treatment goal(s)?</p> <p>GOAL: To treat a disease, reduce rising risk, and avoid serious complications (Moderate Resource Use)</p>	<p>Does the patient have multiple chronic diseases, significant risk factors, complications, and/or complex treatment(s)?</p> <p>GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)</p>	<p>Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?</p> <p>GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)</p>
<p>CARE PLAN SUGGESTIONS</p> <ul style="list-style-type: none"> Preventive screenings and immunizations Patient education Health risk assessment (annual) Appropriate monitoring for warning signs 	<p>CARE PLAN SUGGESTIONS</p> <ul style="list-style-type: none"> Preventive screenings and immunizations Patient education and engagement Health risk assessment (annual) Appropriate monitoring for warning signs Interventions for unhealthy lifestyle/habits Links to community resources to enhance patient education, self-management skills, or special facilities 	<p>CARE PLAN SUGGESTIONS</p> <ul style="list-style-type: none"> Preventive screenings and immunizations Patient education and engagement Health risk assessment (semi-annual) Appropriate monitoring for warning signs Interventions for unhealthy lifestyle/habits Links to community resources to enhance patient education, self-management skills, or special facilities <p>TEAM/PLANNED CARE</p> <ul style="list-style-type: none"> Group visits Home self-monitoring Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings 	<p>CARE PLAN SUGGESTIONS</p> <ul style="list-style-type: none"> Preventive screenings and immunizations Patient education and engagement Health risk assessment (semi-annual) Appropriate monitoring for warning signs Interventions for unhealthy lifestyle/habits Links to community resources to enhance patient education, self-management skills, or special facilities <p>TEAM/PLANNED CARE</p> <ul style="list-style-type: none"> Group visits Home self-monitoring Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings Health coach Referrals, as appropriate 	<p>CARE PLAN SUGGESTIONS</p> <ul style="list-style-type: none"> Preventive screenings and immunizations Patient education and engagement Health risk assessment (quarterly) Appropriate monitoring for warning signs Interventions for unhealthy lifestyle/habits Links to community resources to enhance patient education, self-management skills, or special facilities <p>TEAM/PLANNED CARE</p> <ul style="list-style-type: none"> Group visits Home self-monitoring Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings Health coach/personalized care plan/management and resources Referrals, as appropriate Home health 	<p>CARE PLAN SUGGESTIONS</p> <ul style="list-style-type: none"> Hospitalization Rehabilitation Long-term care Hospice/palliative care <p>TEAM/PLANNED CARE</p> <ul style="list-style-type: none"> Support groups Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings Health coach/care management Referrals, as appropriate Home health Personalized intensive care plan/management and resources

Table 3: Risk Categories and Levels Using Diabetes Example Case

CATEGORY	PRIMARY PREVENTION (Low Resource Use) GOAL: To prevent onset of disease		SECONDARY PREVENTION (Moderate Resource Use) GOAL: To treat a disease, reduce rising risk, and avoid serious complications		TERTIARY (High Resource Use) GOAL: To treat the late or final stages of a disease and minimize disability	CATASTROPHIC/COMPLEX (Extremely High Resource Use) GOAL: May range from restoring health to only providing comfort care
	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
General descriptions of risk levels	No known diagnoses or complex treatments	No known diagnoses but demonstrates warning signs or potentially significant risk factors	Has diagnosis, but stabilized or in control; potentially significant risk factors	Has diagnosis and/or complex treatment, and at higher risk for complications or potentially significant risk factors	Has diagnosis, complex treatment, and complications or potentially significant risk factors— goal is to prevent further complications	<ul style="list-style-type: none"> Very severe illness or condition and potentially significant risk factors End-of-life care Premature baby (May have high costs with limited or no opportunity for improvement, stabilization, or cost control)
Example of using uncontrolled progression of diabetes	<ul style="list-style-type: none"> Healthy 	<ul style="list-style-type: none"> Blood glucose and lipids rising, but still within desired parameters BMI elevated Smoker 	<ul style="list-style-type: none"> Diagnosed with type 2 diabetes, blood glucose, and lipids brought within desired parameters Married, family involved 	<ul style="list-style-type: none"> Blood glucose and lipids not within desired parameters, and financial situation impacting negatively Recently developed Microalbuminuria Depression Lives alone One ER visit and one hospitalization in past year 	<ul style="list-style-type: none"> Has diabetes with early renal disease, coronary artery disease, failing eyesight, and lives alone Developed a foot ulcer Multiple medications Three ER visits and two hospitalizations in past year Dual eligible Medicaid/Medicare Needs Assistance with Activities of Daily Living (ADLs) 	<ul style="list-style-type: none"> Diagnosed with lung cancer Recent myocardial infarction Progression to ESRD with renal dialysis Amputation of one leg Blind Lives in nursing home
Example of care plan considerations for patient with uncontrolled progression of diabetes	<ul style="list-style-type: none"> Preventive screenings and immunizations Patient education and engagement Appropriate monitoring for warning signs Health risk assessment (annual) Care plan that includes smoking cessation counseling and program offered 		<ul style="list-style-type: none"> Recommended preventive screenings and immunizations Appropriate monitoring for HbA1c, microalbumin, LDL Patient education and engagement for medication adherence, diet, and exercise Home self-monitoring for blood glucose Smoking cessation counseling and program Care manager/coordinator visits to manage rising risk Diabetes group visits Referrals as appropriate Community resources such as the YMCA or prescription drug assistance programs Health risk assessment (semi-annual) 		<ul style="list-style-type: none"> Recommended preventive screenings and immunizations Appropriate monitoring for HbA1c, microalbumin, LDL Patient education and engagement for adherence to care plan and medications Diabetes group visits Regular visits with care manager/coordinator Home health for wound management Physical therapy for mobility Care coordination with specialist and other services 	<ul style="list-style-type: none"> Rehabilitation after hospitalization Long-term care Hospice for lung cancer Individualize intensive care management and coordination by care manager/coordinator May or may not conduct preventive screenings Health risk assessment, as appropriate