Applying a Population Health Framework to Develop Integrated PCBH Programs in a Variety of Settings to Address Client Needs

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**Step 1**
Stratify Patients by Risk

**Step 2**
Match Interventions To Risk Level

**Step 3**
Assign the Team

Level 1 (Low Risk)
Health Promotion & Wellness
Level 2 (Moderate Risk)
Health Risk Management
Level 3 (Severe Risk)
Disease Case Management

**CASE EXAMPLE:** Diabetes and Depression

**Level 1 (Low Risk): Health Promotion and Wellness**
PHQ-9 (5-9)/HbA1c (5.7-6.4%)
- ADMIN/MA: Screens/Identifies
- PCP: Ed/Con re: Avoiding Diabetes
- Nutrition: Dietary Options
- OT: Lifestyle Modification/Engagement
- SW: Connect with Resources
- OT/SW/BHC/Psychologist: Address Coping Strategies, Stress Reduction, Adherence to Modifications

**Level 2 (Moderate Risk) Health Risk Management**
PHQ-9 (10-14)/HbA1c (6.5-7.0%)
- MA: Team Consults and Phone Support
- PCP: Assess re: Medication; Refer to Team
- OT: Specific Lifestyle Mod/Engagement, Barriers to Adherence
- PT: Promote Physical Activity
- OT/SW/BHC/Psychologist: Address Depression Symptom Mgmt, Engagement, and Adherence to Modifications

**Level 3 (Severe) Disease Case Management**
PHQ-9 >15/HbA1c (>8%)
- MA/Nurse: Team Consults, Phone Support
- PCP: Assess and Management of Medications
- OT: Environmental Mod/Engagement
- PT: Promote Strength/Mobility
- OT/SW/BHC/Psychologist: Case Management, Specialty Referral, Adherence to Recommendations and Referrals
- Pharmacology: Medication Management, Team Consults

Note: Role/level of team member varies by risk level and provider availability

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